Proceedings of the Workshop on Population Policy for Uttar Pradesh

Identification of Issues

Lucknow, March 2-4, 2000

Organised by

**Department of Medical,
Health and Family Welfare
Government of Uttar Pradesh**

Sponsored by

**The Policy Project
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Ram Prakash

Secretariat Annexe
Government of Uttar Pradesh
Lucknow - 226 001

CHIEF MINISTER
UTTAR PRADESH

Message

The world population is increasing by 8 crores every year and 98% of this growth is in the developing world. On 11 May, 2000 the population of the country is expected to cross 100 crores. It will indeed be a mammoth task to provide a high standard of living to these teeming millions. The Government of India realized early the need to control population, thus we had the first family planning programme in the world in 1952. Recently a National Population Policy has been unveiled which seeks to coordinate these efforts. However the major challenge to population control lies in the northern belt of the country.

The population of U.P. was about 5 crores at the turn of the century and is about 17 crores now. Today we are adding an additional 38 lakh people annually to our already over-crowded State. Unless we take effective steps, the population of U.P. will reach 27 crores in 2023.

Over the years, the Government of U.P. has been trying to improve the quality of life of its people, but inspite of some notable achievements the results have not been commensurate with the aspirations. One important factor leading to this is the galloping population growth, which has come in the way of increasing per capita income and consumption. However, in the last few years there have been some remarkable successes in increasing use of contraception and reduction in fertility. Some very innovative models for providing family planning services through the private sector have also been developed. However, it is important to consolidate these efforts as well as marshal the resources of all the departments in a focussed manner. The development of a State Population Policy is a commendable effort in this direction.

The present publication seeks to identify issues to be addressed and compiles prescriptions from renowned experts from all over the country. It also documents learnings and experiences of programme implementation from U.P. and other States which should be very useful in charting out the future course of action.

I commend this effort and I am sure that it will serve as a good basis for the development of a population policy for U.P.

Date: April 20, 2000

Ram Prakash

Sardar Singh
Minister of Family Welfare
Maternal & Child Welfare

25, Navin Bhawan
Secretariat
Lucknow - 226 001

Message

The family planning programme in U.P. has had some success, but we need to intensify the efforts by improving the quality of services and making them available in an assured manner. There is also the need to broad base the programme by involving the private & commercial sector, NGOs, co-operatives and private medical practitioners. This has been successfully tried out in 15 districts through the efforts of SIFPSA. Other resources also have to be earmarked for filling the gaps in the state health infrastructure and building capacity for delivery of services through large-scale training programmes.

The Government of U.P. has identified population stabilization as a key priority and all efforts will be made to reach the replacement level fertility by the year 2016. The development of a Population Policy for U.P. is an important step in this direction. I am confident that the State Population Policy will go a long way to strengthen the efforts of the Health & Family Welfare department, coordinate them with those of other departments and bring together all resources to achieve the common goal of early population stabilization.

May 2000

(Sardar Singh)

V.K. Dewan
Principal Secretary,
Medical, Health & Family Welfare

Government of Uttar Pradesh
Lucknow - 226 001

Preface

Since its inception the family planning programme of India has emphasized the importance of reducing the country's high rate of population growth and high fertility by making family planning services widely available. Over the past fifty years, the family welfare programme has made reasonable progress in increasing the availability and use of contraception and has undoubtedly contributed to a reduction in fertility. Unfortunately, this has not happened in all the states. The fertility levels in the northern states including Uttar Pradesh, are substantially above the national levels and are offsetting the fertility decline in other parts of India. This also emphasizes a need for a special effort in states like U.P. which can be focussed through a state specific population policy. The U.P. Population Policy will consolidate gains already made, coordinate efforts of various departments, build on innovative successes and cater to the diverse needs of the different geographical regions of the State and also develop a programme of action and an operational plan.

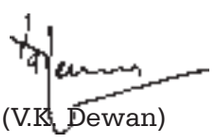
The Government of Uttar Pradesh has decided that U.P. should achieve the replacement level fertility by the year 2016. The Population Policy of U.P. will focus on achieving this objective. To develop a robust policy, a workshop on "Population Policy for U.P.: Identification of Issues & Challenges" was held on 2-4 March, 2000. The main objective of this workshop was to identify specific issues that need to be addressed to achieve replacement level fertility and work out strategies for the same. More than a hundred participants from academia, demographers, social scientists, programme managers both from the Government and the NGO sectors, policy makers and concerned citizens participated in this three-day meet and enriched it with their expertise and experience. Twenty eight papers were presented and discussed in ten technical sessions and a host of issues related to strategy and programme management were thrown up. This document seeks to encapsulate the essence of the deliberations at this workshop.

I am grateful to the Hon. Chief Minister, Shri Ram Prakash, Hon. Minister of Family Welfare, Sri Sardar Singh and the Hon. Minister for Health, Sri Ramapati Shastri for participating in the workshop and making clear their expectations on behalf of the people of U.P. Mr. Yogendra Narain, Chief Secretary, Government of U.P. was a source of inspiration who not only provided us guidance and encouragement, but also chaired an interesting session on advocacy. We are also thankful for the encouragement received from the Ministry of Family Welfare, Government of India and the

guidance from Mr. Gautam Basu, Joint Secretary, Department of Family Welfare, Government of India. I would also like to place on record the efforts made by Ms. Aradhana Johri, Executive Director, SIFPSA and her staff and Dr. Brachchi Lal, Director General, Family Welfare, Government of U.P. and his colleagues in making this workshop a success.

This workshop was sponsored by The POLICY Project which is also making technical expertise available for writing out the policy document. The efforts of Dr. G. Narayana, Director, The POLICY Project and his team in this venture deserve special commendation.

I am sure this volume will be a useful document for all those interested in the family planning and reproductive and child health programme and particularly for policy makers and programme managers. I am also sure that it will prove to be an invaluable document, which will provide the necessary expert underpinning for producing a pragmatic, need based and focussed population policy for U.P..



April , 2000 (V.K. Dewan)

Contents

INAUGURAL SESSION

Welcome and Introduction to Family Planning Programme in Uttar Pradesh
Shri V. K. Dewan, Principal Secretary, Medical, Health and Family Welfare, Government of Uttar Pradesh

Address
Sushri Kristin Loken, Deputy Director, Population, Health and Nutrition Division, USAID, New Delhi

Address
Sushri Aradhana Johri, Executive Director, State Innovations for Family Planning Services Project Agency (SIFPSA), Lucknow

Address
Shri Gautam Basu, Joint Secretary, Ministry of Health and Family Welfare, Government of India, New Delhi

Address by the Guest of Honour
Shri Yogendra Narain, Chief Secretary, Government of Uttar Pradesh

Presidential Address
Shri Sardar Singh, Minister for Family Welfare, Government of Uttar Pradesh

Chief Guest Speech
Shri Ram Prakash, Chief Minister of Uttar Pradesh

Vote of Thanks
Shri Gadde Narayana, Country Director, POLICY Project, The Futures Group International

Inaugural Session

Shri V. K. Dewan, Principal Secretary, Medical, Health and Family Welfare, Government of Uttar Pradesh

I welcome the Hon'ble Chief Minister; Respected Minister of Family Welfare; Chief Secretary; Sh. Gautam Basu, Secretary, Department of Family Welfare; Ms. Aradhana Johri, Executive Director, SIFPSA; Kristin Loken, Deputy Director USAID; Dr. G. Narayana, Country Director, Policy Project; other senior officials; the experts from other states; and the participants.

There is no doubt that the state of Uttar Pradesh has not achieved any milestones in development during the last few years, but one has to accept that the policy of the state Government has always had a rural orientation. It is in this course that decentralization was introduced and panchayati raj institutions (PRIs) were given more powers, so that they could plan and execute their own development programmes. Unfortunately, the growing population is not only hindering development, but also posing a threat to people in availing themselves of basic services and amenities, such as drinking water, education, housing, health services, etc. Therefore, steps towards controlling population have become a must. In my view, efforts towards population stabilization will be the best contribution to development.

The population of Uttar Pradesh was 6 crores in 1951, which increased to 12 crores in 1981, and 14 crores in 1991. The population of the country was 36 crores in 1951, which increased to 68 crores in 1981, and 84 crores in 1991. These figures make it amply clear that the population growth rate in Uttar Pradesh has been much higher than the all-India growth rate. The total fertility rate (TFR) in the country is about 3 children per woman, whereas in Uttar Pradesh it is 4. According to the latest National Family Health Survey (NFHS) II, family planning efforts have shown some encouraging results. If we compare the data of the NFHS I (held in 1992–1993) with the latest survey, we will find that the progress made in achieving a lower TFR during the last six years is equal to the achievement of the last 40 years. In 1992–1993, the TFR was 4.8, which was reduced to 4 in 1998–1999; in 1991, it was 6. The survey also reveals that the number of couples using contraceptives has increased by about 40 percent. The percentage of such couples increased to 28 percent in 1998–1999 from 20 percent in earlier years. A decline of 11 percent in *nasbandi* (sterilization) cases has been registered, which makes it evident that spacing methods are becoming more and more popular, and the participation of the private sector in supplying contraceptive oral pills and Nirodh has increased. Tetanus toxiod (TT) immunization

of pregnant mothers has increased by one-third, from 37 percent in 1992–1993 to 51 percent in 1998–1999. Last year, the Government of Uttar Pradesh launched a campaign for TT immunization of pregnant women. As a result, 35 lakh pregnant women were given TT injections and iron and folic acid (IFA) tablets. An independent survey has revealed that this campaign has increased our coverage by 30 percent. These achievements are commendable especially in view of the fact that Uttar Pradesh is far behind the all-India average with regard to health indicators. The Government of Uttar Pradesh can be credited with a number of achievements in implementation of family welfare programmes.

Here I would like to inform the participants that Uttar Pradesh has achieved more than any other northern state (Bihar, Madhya Pradesh, and Rajasthan) in terms of spacing methods, use of modern contraceptives, TFR, couple protection rate (CPR), etc. We can see a ray of hope in the near future. This workshop on "Population Policy," organized by the Uttar Pradesh Government and the Policy Project of The Futures Group International, is a relevant step at this juncture. Working together we can succeed in controlling the situation of population growth. This is a difficult challenge, but not an impossible one.

In the next 15–16 years, we will have to lower the fertility rate from the present level of 4 to 2.1. Along with this, if in the coming five years we are able to carry out such programmes as the Reproductive and Child Health Programme, we will see a clear reduction in population growth.

I convey my good wishes for the success of this workshop, which I hope will contribute significantly in the ongoing efforts of population control in Uttar Pradesh. I, once again, convey my gratitude to the Hon'ble Chief Minister who spared sometime from his busy schedule to participate in this workshop. I am also thankful to the Honourable Family Welfare Minister for his commitment, which was evident from the way he showed interest in the mass awareness week. I am grateful to the Chief Secretary of Uttar Pradesh, who has been a source of inspiration for me. About 4–5 months back, when we were working on the Population Policy for Uttar Pradesh, we found that it was necessary to get inputs from our technical experts. I would like to thank the Joint Secretary, Shri Gautam Basu, who is present among us, for his inspiration, which resulted in holding this workshop. He played an important role in the formulation of the National Population Policy announced by the Government of India recently. I am hopeful that he will greatly contribute in the coming technical session of this workshop.

Lucknow is famous for its hospitality and its unique etiquette. It has its own culture. I hope we will be able to leave an impression of this hospitality and etiquette on all the participants, many of whom have come from other states. I once again thank you all.

Ms. Kristin Loken, Deputy Director, PHN Division, USAID

Shri Ram Prakash, Shri Sardar Singh, Dr. Yogendra Narain, Shri V. K. Dewan, Shri Gautam Basu, Sushri Aradhana Johri, Dr. Narayana, friends and colleagues.

Thank you for the invitation to the workshop. I am delighted to be here today. At the outset, I would like to congratulate the Chief Minister and the Chief Secretary and the Uttar Pradesh administration for taking the initiative for developing a comprehensive Uttar Pradesh State Population Policy. This is a critical step in both improving health status as well as meeting family planning needs of couples in Uttar Pradesh.

At this momentous occasion I would like to reiterate the long-standing and invaluable partnership between the Government of United States and the Government of Uttar Pradesh. Our collaboration began with the setting up of Indian Institute of Technology (IIT), Kanpur, and since then we have successfully worked together on a number of development projects.

As you may be aware, we are currently supporting the IFPS or the Innovations in Family Planning Services Project in Uttar Pradesh. This is the largest family planning and reproductive health initiative supported by USAID anywhere in the world.

The reason we are providing substantial support to the IFPS Project is that we share your belief that if we can make a difference in the most populous state in India, we can have tremendous impact not only in Uttar Pradesh, but also globally. The magnitude of the impact that Uttar Pradesh has on the world is evident from the fact that if the state were a nation, it would be the fifth largest country. Therefore, a tremendous opportunity exists for making a difference in the lives of 1 of every 36 persons in the world—and USAID continues to stand ready to support you in this effort.

However, the task of reaching replacement level fertility in Uttar Pradesh, in which each couple only has two children, is challenging but not impossible. In India, several southern states have already reached replacement level fertility and other states, such as Maharashtra, are also rapidly moving towards replacement fertility. Even in the four northern states of Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar, there is movement in the right direction. If the other states of India have been successful, there is no reason why replacement fertility is not achievable in Uttar Pradesh.

I believe that without political will the best of policies and plans cannot have the desired impact. I am delighted to note that there is strong political will, which is evident from the fact that the state recognizes the need to have a state-specific population policy that meets the needs of the people of Uttar Pradesh

In order to implement the new policy, the Government of Uttar Pradesh will also need additional resources. I was pleased to note that the Government has increased the budget for Family Welfare Services in the recent budget just announced by 20 percent. I hope this would, in turn, mean that the states would also be provided with additional resources for the program.

Now, I would like to move to another issue and that is of unmet need. Available data indicate that 30 percent of the couples in Uttar Pradesh who either want to wait for two years before having their next child or do not want any more children are not using any method of contraception. This clearly indicates that there is a large need for contraception that is not

being currently met by the program. The Government of Uttar Pradesh can make a substantial contribution to meeting the fertility and reproductive health needs of people. This level of unmet need also indicates that people want to have fewer children; providing incentives and disincentives may not be necessary and, in fact, could be counter-productive. Experience from the IFPS Project seems to indicate that this need might better be met by expanding access to high-quality family planning and other reproductive health services and by providing adequate information and appropriate counseling.

In order to meet the vast unmet need for reproductive health services, it is also imperative to recognize the role of the private sector. Over three-fourths of all condoms and pills used in Uttar Pradesh are provided by the private sector. The task at hand is huge, and the Government alone cannot meet the varying needs of the clients. For optimum utilization of resources, it is important that Government build effective partnerships with the private sector to meet the reproductive health needs of its people.

Under the IFPS Project, SIFPSA is already working towards building capacities in both the public and private sectors to provide quality family planning and maternal health services. SIFPSA is currently supporting about 100 NGOs, which through a network of 10,000 community-based workers are striving to meet the reproductive health needs of the people of Uttar Pradesh

Before concluding, I would once again like to congratulate the Government of Uttar Pradesh for initiating the process of development of a Uttar Pradesh State Population Policy. Given the cultural, religious, linguistic, and ethnic diversity among states, it is important for states to develop their own strategy for providing quality services that meet the varying needs of their people. USAID is delighted to be a partner in this very important endeavor by providing technical assistance through the POLICY Project of The Futures Group International.

I look forward with anticipation to three days of deliberations for identifying key issues pertaining to the development of population policy.

Ms. Aradhana Johri, Executive Director, SIFPSA

Hon'ble Chief Minister, Hon'ble Family Welfare Minister, Dr. Yogendra Narain, Mr. Dewan, Mr. Gautam Basu, Dr. Narayana, representatives of the Government sector and industry, media, and all the respected guests.

This workshop, which is being organized with the objective of formulating family welfare policy, is an important event. Uttar Pradesh has remained the most populous state of India, since the time of independence. The population control efforts in this state have a direct bearing on the population of entire country. Recent trends suggest that there is progress in the area of family welfare in the state.

The Government of India conducted surveys last year to gauge the progress made in relation to various aspects of family welfare, and mother and child welfare. In Uttar Pradesh, a world famous institution, called A. C. Nielson, conducted this survey. The initial results of this survey suggest that the total

fertility rate in Uttar Pradesh has decreased in recent years. Similarly the CPR has also increased. Still, Uttar Pradesh is behind the all-India standards. But what gives us hope is that the recent trends are positive and indicate signs of progress. This has been made possible by the joint efforts of SIFPSA, which is operating in 15 districts of the state in a major way, and of the state administration and private sector. The objective is to use the available resources of society for providing more family welfare services and creating and increasing demand for these services.

The concrete results of the project are becoming visible now. This year, USAID, which is providing funds for this project, conducted a survey that revealed that those districts where SIFPSA is working are showing better results. During the last four years, the use of modern techniques of family planning, or the CPR has increased seven times compared to other districts surveyed. Another optimistic indicator is that one-third of the users of family welfare methods are now using spacing methods, whereas in other districts this figure is 25 percent. In Uttar Pradesh, the average age at marriage for women is 15–16 years, and they adopt sterilization methods at ages 28–29. What is needed is to ensure the use of spacing methods during this interval of 13 years; otherwise, women end up having about five children by the time they undergo sterilization. This is of little benefit to the users of sterilization or to controlling population growth. This makes use of spacing methods all the more necessary. Thus, the increase in the users of spacing methods in districts where SIFPSA is working is a healthy sign. Similarly, progress has been made in these districts in the field of mother and child welfare.

I am really grateful to Honourable Chief Minister and Family Welfare Minister to spare time for this workshop. If leadership is provided from the top level, this programme is bound to succeed. I am also grateful to the experts who have come here to share their views and knowledge. I am hopeful that this interaction of experts and officials of the sector and other organizations will result in a holistic and pragmatic policy.

Shri Gautam Basu, Joint Secretary, Ministry of Health and Family Welfare, Government of India

Hon'ble Chief Minister, Hon'ble Minister of Family Welfare, Chief Secretary, Principal Secretary, Health and Family Welfare, PHN Deputy Director, USAID, Dr. Narayana, Ms. Johri, distinguished delegates, ladies and gentlemen.

It is a great pleasure on my part to represent the Ministry of Health, Government of India, on this glorious occasion. For the past 3–4 years, Uttar Pradesh has been taking certain major initiatives in the health sector, which have not escaped anybody's notice. And the vast problems, the massive context in which this work is being attempted, all these things are also known to the world. The National Population Policy that has been recently approved by the Government is being tabled before Parliament shortly. It has already given rise to a good deal of debate and deliberation in the country, which we think will be good and will be beneficial for the development of the entire health sector. The policy paper provides not only ambitions and ambitious

goals, but also a holistic picture of the current status of the inadequacies in the existing situation and what needs to be done. In addition, the paper provides the kind of investment to be made, the kind of scenario, and the kind of linking with NGOs, the private sector, the PRIs, national resources and how those resources can be marshaled. Even before the announcement of the National Population Policy, some state Governments already took the lead to announce their own population policies and strategies. I think one can recall Madhya Pradesh and also Rajasthan. But one is waiting for the population policy of Uttar Pradesh.

In Uttar Pradesh, when one talks of any sector, social sector, infrastructure, etc., all eyes of the Government of India are naturally focused on Uttar Pradesh, not only because of its gigantic size but because of the central position the state has occupied, historically, geographically and also culturally in India. Once the population policy comes out after a great deal of consultation and debate, the unmet need of the whole sector will have a chance to be addressed. And everybody is now talking of the need for focusing more attention on the entire social sector, on health and education, on the need for investing more, and on the need for allocating more resources than all these sectors have had access to. As to this policy, state-specific policies will also address those needs. And a state as vast as Uttar Pradesh very naturally needs its own policy. It cannot be dictated only by policies and practices at the national Government level. So, this is a very happy occasion, and we do hope that within the near future, debate will start and all this will lead to a wholesome, implementable, and pragmatic population policy for Uttar Pradesh. We are also assembling here on the occasion of the release of the NFHS II data.

When the NFHS I came out first with its report in 1992–1993, it yielded a wealth of information, and it revealed a lot of facts, which within a few years, enabled the Government of India to reform and change its own policies in consultation with the states, with the private sector, and with NGOs. In fact, the information from NFHS I led almost naturally to the paradigm shifts, to withdrawal of targets, to acceptance of the reproductive and child health (RCH) approach, and to the policies and practices affording a wide range of choices to the people. The main task of the Government was to meet unmet need, and not to really try to impose artificial targets from the top. The NFHS II results, which have now come out, will give us an excellent opportunity to test the doctrines and the reforms that have been carried out. How far have the policies been successful with the removal of targets? In fact, I still remember in 1995–1996 the removal of targets when the results in terms of numbers showed certain declines in states like Uttar Pradesh. Concern was expressed in all quarters, but the increase in the use of spacing methods, which Aradhana has referred to now, fills us with hope that the reforms and the new directions are in the right place. At the same time, we must also realize that we have a wealth of data and information from other sources. We have sample registration system (SRS) data and RCH household surveys. One-half of the total districts in the country, including one-half of the districts in Uttar Pradesh, were covered and the reports are available now. Luckily,

the other half also has been covered now and the reports are available. So there is a need for us to compare objectively all the data and information flowing out of all these multiple sources. But the task is huge and any information gleaned from these sources should not lead us to complacency. I have to mention this on behalf of the Government of India because, as I said, if Uttar Pradesh sneezes all India catches cold. Similarly, if anything good happens in Uttar Pradesh, the entire country will benefit from it. So we do hope that all these exercises will soon lead to a new thrust in the family welfare sector in Uttar Pradesh and that the entire country will benefit.

Dr. Yogendra Narain, Chief Secretary, Government of Uttar Pradesh

Hon'ble Chief Minister, Hon'ble Family Welfare Minister, Ms. Kristin Loken, Deputy Director, PHN, USAID, Dr. Narayana, Mr. Gautam Basu, and our officials and guests from various states and various organisations.

Such a workshop on family planning and family welfare is being organized after many years. It was necessary because we felt that if we do not control population growth, it will hamper our development. We had initiated an effort in this direction last year, and a draft population policy was formulated. When the central Government and other state Governments came out with population policies, we felt it all the more necessary to formulate such a policy and to seek assistance of experts and professionals. Mr. Gautam Basu, Joint Secretary, Government of India, said earlier that the events in Uttar Pradesh have an impact on the entire country. This is true. Similarly, it is also true that whatever happens in India has a bearing on the world. India's population is one-sixth of the world population and population of Uttar Pradesh is one-sixth of our country's population. Therefore, whatever takes place in Uttar Pradesh has a bearing on India, which again has a bearing on the world scenario.

In 1951 our TFR was less than the all-India average. The India TFR was 6.4 whereas our's was only 6. But, according to the 1991 census (i.e., after 40 years) the all-India TFR average was 3.4, whereas the TFR of Uttar Pradesh was 5.1.

Currently, the TFR of Uttar Pradesh has declined to four. However, it is significant to note that the decline in the TFR in the last eight years is almost equal to or more than the decline in the TFR in the previous 40 years. As Gautam Basu*ji* and Dewan Sahib have mentioned, earlier the TFR of the state, according to the NFHS I, was 4.8 in 1992–1993 and declined to 4.0 in 1998–1999.

Our literacy rate is also increasing. We have very encouraging figures on the literacy rate, which was only 29 percent in 1951, but increased to 41 percent in 1991. According to the Government of India's survey, the literacy rate for 1998 was 56 percent, which means there was an increase of 15 percentage points in just seven to eight years. I think that the progress achieved in the literacy rate and family planning efforts are due to the information explosion through mass media and television. They are making a great impact on our family planning programme. Credit for these encouraging gains goes to the efforts of the state Government on the one hand and to contributions made by SIFPSA on the other.

USAID, whose representative is among us, has been assisting this programme since 1993–1994. As Ms. Aradhana Johri has told us, the SIFPSA project districts have registered an increase in CPR. The CPR in these districts has increased by 5.1 percentage points, whereas in other districts this increase is just less than one percentage point. This confirms our belief that if we involve more non-Governmental organizations, the programme can be made more effective.

The Honourable Chief Minister and Family Welfare Minister are also present here, who will tell as about the efforts being made by the Government of Uttar Pradesh. But discussions at the official level both at the centre and in the state have created a sense of confidence among us, and we feel that our family planning programme is becoming a mass movement in a spontaneous way. Apart from this, the devolution of power under Panchayati Raj will soon have its impact on this programme. I am hopeful that if we could finalize population policy with your help and put it in practice without delay, we are sure to achieve the TFR of 2.1 by the year 2021. If we are able to achieve this goal, it will have tremendous implications for the development of our state. Presently, in terms of economic growth rate (5.9), we are far behind China (10 percent), but with this achievement, it will be possible for us to attain that level. This is because we have a vast market, we will have to spend less on anti-poverty and social welfare programmes; as our population will be less, we will be able to pay more attention to our industry, and our investment will increase, which in turn, will speed up economic growth.

Shri Sardar Singh, Minister for Family Welfare and Women and Child Welfare, Government of Uttar Pradesh

Respected Chief Guest, Sh. Ramprakashji, Hon'ble Chief Minister, Uttar Pradesh, Dr. Yogendra Narain*ji*; Chief Secretary, Uttar Pradesh; Sh. V. K. Dewan*ji*, Principal Secretary, Medical, Health and Family Welfare, Uttar Pradesh; Sh. Gautam Basu*ji*, Joint Secretary, Ministry of Health and Family Welfare, Government of India; Ms. Kristin Loken, Deputy Director, PHN, USAID, Ms. Aradhana Johri, Executive Director, SIFPSA, other representatives of Government of India, Uttar Pradesh state Government, officials from SIFPSA, journalist friends, and the participant ladies and gentlemen.

I welcome you all and hope that today's workshop will come out with valuable recommendations that will provide us guidance. You all know that Uttar Pradesh is the most populous state of the country. In 1951, it had a population of 6 crores, which increased to 12 crores in 1981 and presently the state has a population of 16 crores. Thus, in every 30 years the population of the state is doubling. If this rate of increase continues, by 2031 the state's population will reach to the mark of 30 crores. Thus, this is the appropriate time to ponder this problem and develop a concrete strategy to control the increasing population. The Uttar Pradesh Government has made consistent efforts through the Family Welfare Programme to put a check on increasing population. One such initiative is the introduction of the target-free approach. Now the family welfare programme is being planned on the basis of real demand. Cooperation of gram pradhans, panchayat members, teachers, private practitioners,

Members of Legislative Assembly (MLAs) and other influential people is being sought for this purpose.

Work plans of primary health centres are being made after consolidating the work plans of subcentres under it. Similarly, the work plan at the district level is being worked out by consolidating the work plans of all the primary health centres falling under the district. In this order the work plan for Uttar Pradesh will be based on the work plans received from the districts.

To give a fillip to the ongoing family welfare and mother and child welfare programmes, the RCH scheme was introduced in April 1997. Apart from mother and child health facilities, information about reproductive tract infections, sexually transmitted infections, and AIDS has been included under this programme. All these services have been integrated with the objective of emphasizing the need to pay attention to reproductive health of women and prenatal and postnatal care, and also to popularize the concept of limited family size. For this, funds are being provided by the World Bank and SIFPSA. This project has started showing results now. The public sector on the one hand registered major achievements in providing services like male and female sterilization and Copper T, the private sector has made appreciable contributions to the propagation of small family norm, and distribution of contraceptives such as Nirodh and contraceptive oral pills. SIFPSA, by integrating the efforts of both sectors was able to give an impetus to the family welfare programme as a whole. Efforts of SIFPSA have shown encouraging results.

According to the NFHS II, in the last six years, the achievement of Uttar Pradesh in the field of family planning is equivalent to its achievement of the previous 40 years. Some indicators, such as a decline in the TFR and infant mortality rate (IMR), an increase in TT immunization of pregnant women and an increased the use of contraceptives, suggest that we are getting good results of the family welfare programme. Now the time has come to provide this programme a further impetus in order to bring the state indicators in line with the national average. The private sector and SIFPSA, along with the Department of Health and Family Welfare, has played a significant role in achieving these goals. While the family welfare services are being made accessible in rural areas through RCH camps and there is a marked increase in sterilization and Copper T services in the state sector, the maintenance of community health centres, primary health centres and subcentres is being done through SIFPSA, which has brought a qualitative improvement in health and reproductive services. SIFPSA is also trying to make family welfare services available to each household through voluntary organizations and dairy cooperatives. Recently, SIFPSA organized the "Awareness Week" successfully, which spread the message of family welfare in 700 villages and towns of 15 districts covering a population of 10 lakhs. Last year, a similarly successful campaign included a TT immunization and polio campaign. Given this background, this workshop is quite significant and timely. I hope it will develop a population stabilization strategy, which is not only viable but will help in bringing state population indicators on par with all-India indicators in a timely manner. This will help

the country and state achieve the objective of population stabilization. I am convinced that this workshop, which is the joint initiative of the Uttar Pradesh Government and The Futures Group International, will prove a meaningful effort.

I congratulate the organizers of this workshop. I assure the Honourable Chief Minister that we will try with all our devotion and sincerity to carry out his instructions and implement the population stabilization policy. As other speakers and Narain*ji* have said, we are faced with an explosive situation in our state and our development is not visible. I assure you all that the population stabilization policy and the recommendations of this workshop will be implemented with sincerity. This will help us to control this explosive situation of population growth in our state. We will make Uttar Pradesh a lively, vibrant, and flourishing state. With these words, I welcome all the guests and invitees.

Shri Ram Prakash Gupta, Chief Minister, Uttar Pradesh

Hon'ble Family Welfare Minister, Sh. Sardar Singh*ji;* Chief Secretary; Principal Secretary, Medical, Health and Family Welfare; Ms. Aradhana*ji,* SIFPSA; Sh. Gautam Basu*ji*, Joint Secretary, Government of India, Ms. Kristin Loken, Deputy Director, PHN, USAID; experts from other states, our guests, officials of the state Government, and friends from the media.

First of all, I would like to welcome you all on behalf of the people of this state. Lucknow is a beautiful city with a long cultural heritage. I hope when you visit the city that you will like its etiquette and culture, buildings and architecture.

Friends, we have made considerable progress in the area of family welfare. But the problem of population is a very complicated one. One approach towards population is direct (i.e., to reduce population). But do not misunderstand me. I want to draw attention to the fact that with population explosion, the quality of society is also declining. The gap between rich and poor is increasing. The intelligentsia is adopting family planning measures, but the illiterate and poor are not. As a result, that class is increasing in numbers, affecting the quality of society as a whole. The second thing I would like to say is that we try to inspire people to adopt family planning, but there is another trend in society that restrains them. For instance, during the Emergency, forcible sterilizations were done on a large scale. The entire society reacted to this, resulting in people opposing family welfare. This affected the Government, and since we have democracy, every class of people wants to increase its say and wants its population to increase. Thus, this is the major reason for the failure of our efforts. I want to draw your attention to this fact. We will have to consider what various classes think. There are some classes that are increasing their population numbers, and these classes are responsible for the population explosion. The question is how these classes can be brought to use family planning, and where to concentrate our efforts.

We are in the process of formulating a policy for Uttar Pradesh, for which we will also get inputs from you, and we are going to announce our Population Stabilization Policy in the next three months. Although we have not taken any decision so far, we are considering certain provisions that we have noticed in other states.

Debarring people having more children from contesting in elections can be one such provision. This is necessary because there is a feeling that to win elections, the population must be increased. But when this trend is stopped, this class will realize that having more children will serve neither the purpose of having more voters, nor bring their candidates to power. If the Government and society concentrate on those classes whose population is increasing, then improvements can be made faster and real change in the situation can take place.

If we successfully take the message of family planning to the poor, we can ensure a big change in society and maintain its quality. So friends, you will be doing important work in coming three days. Please advise and tell us what steps can be taken to tackle the problem of population growth. It is necessary on the one hand to expand the scope of family welfare and mother and child welfare and health services. But at the same time, we will have to make efforts to inspire the society to adopt the family planning methods and reduce population. We have the example of China, which, although not a democratic country, has controlled the population growth, thus resulting in an increase in China's overall economic growth rate. But despite this large population, our economic growth rate is also increasing. We are feeding the entire population and also developing. This is not a small achievement.

At the time of independence, India did not have enough food grains to cater to the needs of its population; however, today the country is in a position not only to feed its population, but also to create a surplus of food grains. Therefore, I feel that as far as development is concerned, we are in a good position. This fact should not be underestimated. And, as in the case of China, we can also accelerate the pace of development by population stabilization. This is what I feel. There is a need to have a population policy for the state. In this context, this workshop is a very timely effort. The participants of this workshop—population experts from the country and abroad, representatives of various organizations and agencies—can deliberate on these problems and develop a concrete and effective population policy. What I would like to see developed is a well coordinated, holistic policy, which encompasses not only the areas of family welfare and medicine, but also other related areas, such as women welfare, nutrition, food, poverty eradication, etc. In view of the complexity of this problem, it is necessary to involve and seek the cooperation of NGOs, industrial units and cooperative societies to create a mass movement for change. What I would like to have is a population policy based on the real needs of Uttar Pradesh. At the same time it is also necessary to point out the resources required for implementing this policy, in order that the policy is viable. I want this policy to be a time-bound programme, so that in coming 15–16 years, Uttar Pradesh will be able to achieve the "two-children per family norm."

I sincerely believe that in the coming three days, workshop participants will discuss at length various aspects and develop recommendations that will help in formulating a viable, effective and purposeful population policy for the state. I once again welcome you all. Thank you.

Shri Gadde Narayana, Country Director, POLICY Project, The Futures Group International

The presence of the Hon'ble Chief Minister on this occasion is a source of inspiration and encouragement for us. Sir, with your blessings through this workshop, we will be able to develop a concrete population policy for Uttar Pradesh. I am grateful to you that you could spare some time to attend this workshop. I hope you will continue to guide us in the formulation of this policy. I convey my gratitude to you on behalf of all of us. Guidance from Dr. Yogendra Narain, the Chief Secretary of Uttar Pradesh, will help us in formulating an effective population policy. I thank Dr. Yogendra Narain*ji* for his participation in this workshop. I would like to thank Shri Sardar Singhji, Family Welfare and Mother and Child Welfare Minister for his guidance, help and encouragement. Mr. V. K. Dewan, the Principal Secretary, Medical, Health and Family Welfare, Government of Uttar Pradesh, has spent his invaluable time in creating this workshop. His presence has provided us not only direction, but also given us inner strength. I hope in future he will guide us in a similar way. The presence of Ms. Kristin Loken, USAID, and Mr. Gautam Basu was a great help to us. I express my sincere thanks to them.

Organizing this workshop was certainly not possible without the cooperation and guidance from Ms. Aradhana Johri, Executive Director, SIFPSA. She was there at every step, with her suggestions and guidance. I do not have the words to thank her for her invaluable cooperation. At last, I thank you all for accepting our invitation to participate in this workshop.

I once again convey my thanks to the Honourble Chief Minister, Honourble Family Welfare and Mother and Child Welfare Minister, Shri Sardar Singh*ji*, Shri Yogendra Narain*ji*, and all the esteemed guests. On behalf of the Department and the POLICY Project, I am also grateful to the participating experts and officials and firmly believe that their ideas and knowledge will help us to formulate a holistic and comprehensive population policy that people are able to accept on a voluntary basis. With these words of greetings, I take leave. Thank you all.

SESSION I

POPULATION OF UTTAR PRADESH

Chairperson: *V. K. Dewan*

Uttar Pradesh: Population Trends
Sheena Chhabra

Recent Trends and Regional Variations in Fertility in Uttar Pradesh: Causes and Correlates
P. N. Mari Bhatt

Fertility Transition in Uttar Pradesh
F. Ram, Arvind Pandey, T. K. Roy, Zaheer Khan

Discussants: *P. M. Kulkarni and T. K. Roy*

Session I

Population of Uttar Pradesh

The main objective of this session was to understand the population growth rate and fertility behaviour in Uttar Pradesh. Several surveys conducted recently help to analyze the trends and patterns of behavioural change. The three papers presented in this session dealt with a variety of issues that have relevance to population policies of Uttar Pradesh, particularly objectives to be set to reach replacement level fertility.

Remarks of the Chairperson

V. K. Dewan

The demographic data are extremely important for the formulation of population policy. Declining trends of fertility and mortality and the pace at which the decline has been happening are important to set future objectives and goals. For instance, regional variations are very important, not only in terms of contraceptive prevalence rates, but also in terms of maternal and child health (MCH) services. In terms of policy, we need to see which areas require more attention. There are also other factors that influence fertility behaviour such as education, status of women, decision making in the family, and age at marriage. We need to discuss various aspects to understand the fertility behaviour and changes. The three papers in this session will throw light on these aspects and several related issues.

Uttar Pradesh: Population Trends

Sheena Chhabra

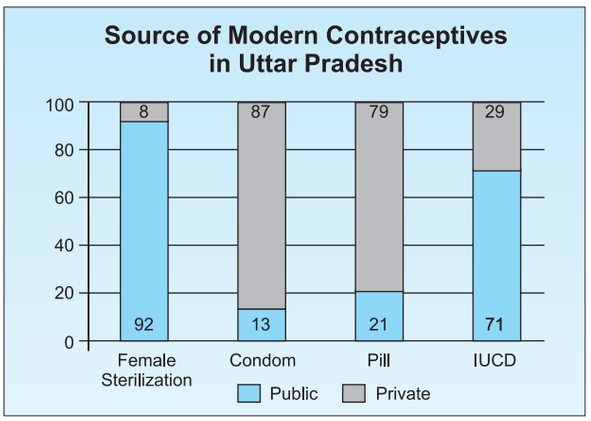
In the last 50 years, the world population has increased from 2.6 to 6 billion persons. Another 1.5 billion will be added in the next 20 years. That really means that we would be adding the population of East Asia to the world. A lot of this growth will be in the developing countries. In that context, therefore, it is important to see what is happening in India, where the population has grown from about 238 million in 1901 to 1 billion today. There has been a four-fold increase in the population size in the last 100 years. India accounts for nearly one-sixth of the world population, and one-sixth of India's population is in Uttar Pradesh. In the global context, one out of every 36 persons on earth is from Uttar Pradesh.

Population growth, the difference between the birth rate and the death rate, needs closer

examination. In the last 28 years in Uttar Pradesh, the death rate has fallen considerably from 22.5 to 10.5 per 1,000 population, a decline of about 53 percent. During the same period, the birth rate has declined by 27 percent from 44.5 to 32.4 per 1,000. As a result, the population in Uttar Pradesh has been growing at about 2.2 percent per year in the last three decades. Compared to India, the death rate in Uttar Pradesh is slightly higher but there is a larger gap between India's birth rate and that of Uttar Pradesh. Thus, the population of Uttar Pradesh is growing at a higher rate compared to the population of India.

Substantial progress has been made since the introduction of the family planning programme in Uttar Pradesh. The programme has contributed to a decline in fertility; in Uttar Pradesh, fertility has declined by about 20 percent in the last 45 years, and family planning method use has increased from 2 to 28 percent during that period.

Thus, it is necessary for us to determine how soon Uttar Pradesh is likely to achieve replacement level fertility and, subsequently, population stabilization. There are three possible scenarios. In the first case, if Uttar Pradesh reaches replacement level fertility by 2016, the population will stabilize at about 290 million. The implication of this is that another 120 million will be added to the current population of 170 million. If Uttar Pradesh achieves replacement level fertility by 2036, the population will stabilize at 360 million, which is almost twice the size currently. If Uttar Pradesh reaches replacement level fertility by 2041, the population will stabilize at 420 million, or 2.5 times the current population size.

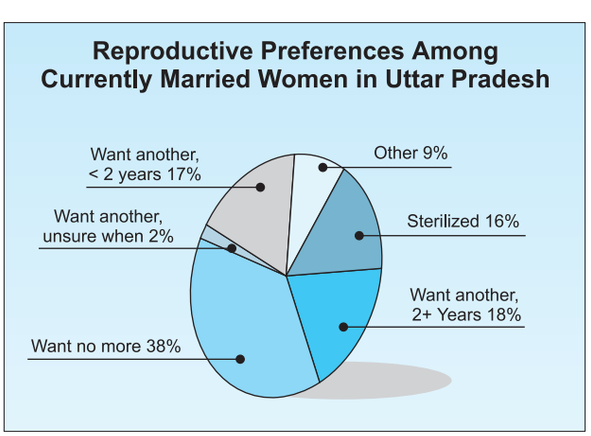


Implications of reaching replacement level fertility by a certain year must also be looked at mainly in terms of the extent of increase required in the CPR. If the main objective in Uttar Pradesh is to reach replacement level fertility by 2016, the CPR has to increase from 28 to 61 percent. Translated into number of clients, there has to be a threefold increase in the number of clients served by the programme during this time period. Recent survey results suggest that 28 percent of couples in Uttar Pradesh currently use family planning methods, and female sterilization is the predominant method used. The method mix may undergo major changes depending on the type of methods preferred and the type of services that can be provided.

In terms of source mix, broken into private and public sources, female sterilization is predominantly provided by the public sector. In case of IUCD users, seven out of 10 users receive their services from the public sector. However, for other methods such as condoms and pills, the private sector is the predominant source. What are the fertility preferences of currently married women of reproductive age in Uttar Pradesh?

Preliminary data from the NFHS indicate that there are about 18 percent of couples who want another child after only two years, and 38 percent of couples who do not want any more children. Therefore, 56 percent of couples either want to delay having a child or do not want another child. Nearly 12 percent of these couples are currently using spacing methods. If these couples are excluded, 44 percent of couples in Uttar Pradesh today either do not want to have a child or want to wait for another two years. Thus, a lot of latent demand exists for family planning in Uttar Pradesh.

Although the task of reaching replacement level fertility is daunting, it can be achieved given the huge latent demand. The challenge is to convert latent demand into actual use by expanding access to services. It is impossible for the Government alone to cater to that demand, however. There is a need to place greater emphasis on marketing channels. A large number of condom and oral pill users are buying either subsidized products from the Government or fully commercial products from retail outlets. Since potential demand is not getting converted into full use because of various concerns, there has to be a generic demand-creation campaign addressing the concerns of the people. In addition, about 25 percent of couples do not have a felt need for family planning today. Thus, a communication campaign targeted at this segment is also needed. If the policy focuses on these issues, it is possible to achieve replacement level fertility earlier than expected in Uttar Pradesh.



Recent Trends and Regional Variations in Fertility in Uttar Pradesh: Causes and Correlates

P. N. Mari Bhat

The objectives of this paper are twofold: to address recent trends in fertility in Uttar Pradesh by critically reviewing the data from the Sample Registration System (SRS) and NFHS I and II; and to examine, with the help of geo-mapping and regression analysis, the regional variations in fertility and some of their correlates. District-level data from the 1991 census, supplemented to some extent by the Reproductive Health Survey of 1998–1999, are used to study the regional variations.

Using indirect techniques, it can be concluded that birth registration in the SRS was 98 percent complete in Uttar Pradesh from 1990–1997, while death registration for ages above 5 years was incomplete by about 6–11 percent in the same period. Given this, the SRS crude birth rate would require an upward correction of the order of 1 per 1,000, and life expectancy estimates would require a downward correction of the order of one year in Uttar Pradesh.

The NFHS I and II-assessed total fertility rates (TFR) are based on births occurring 0–3 years

prior to the survey. The TFR estimate was 4.8 for 1992 and 4.0 for 1997. Thus, there is a decline of nearly one birth per woman during the six-year period, which amounts to a 17 percent decline in fertility. The decline in TFR for the same period as per SRS estimates is only 7.5 percent. Which of these estimates is correct is an important question that must be addressed.

Fertility rates can be examined in two parts: fertility rates of younger women (i.e., 15–30 years), and number of births to women over age 30. TFR estimates for younger women in both NFHS I and II were slightly higher than the SRS estimates. The decline in the fertility rate during the six-year period was 9.3 percent as per the NFHS estimate and 7.3 percent as per the SRS estimate. Differences in NFHS and SRS fertility estimates of younger women were marginal. However, in the fertility estimates of the older age group (30–49), there is a significant difference between NFHS and SRS in both rounds. The implied decline in fertility for this age group was 33 percent as per NFHS, while the decline was only 7.9 percent as per SRS. If fertility has declined among older women, the higher order births should also decline. However, a comparative analysis of NFHS I and II for birth order six and above showed a decline of only 1 percentage point from 19 percent in 1992 to 18 percent in 1997. The birth order distribution has not changed.

Contraceptive prevalence increased from 20 percent in NFHS I to 28 percent in NFHS II. There also was a slight increase in use of contraceptive methods in older women. However, this increase can explain only a 16 percent decline in the TFR among older women, and not 33 percent in NFHS II.

There are significant regional variations in fertility behaviour in Uttar Pradesh. Regional patterns in fertility and contraceptive practice are examined using birth-order-based estimates of TFR and model-based estimates of the index of marital fertility control derived from the fertility data of the 1991 census. Regional variations in fertility in Uttar Pradesh arise primarily out of variations in contraceptive practice. Variations in female age at marriage contribute little to variations in fertility, perhaps because, owing to a homeostasis mechanism, females marry early in regions where natural fertility levels are lower. That is, female age at marriage works primarily as a counter balancing factor for variations in maternal fertility.

Levels and Trends in Total Fertility by Source: Uttar Pradesh 1990-1997

Indicator	NFHS I 1990-1992	NFHS II 1996-1998	Percent Change	SRS 1990-1992	SRS 1997	Percent Change
TFR 15-49	4.82	3.99	-17.2	5.17	4.78	-7.5
TFR 15-29	3.22	2.92	-9.3	3.01	2.79	-7.3
TFR 30-49	1.60	1.07	-33.1	2.16	1.99	-7.9

Comparison of Birth Order Distributions form NFHS I and NFHS II: Uttar Pradesh 1990-1997

Source	Order of Birth				
	1	2-3	4-5	6+	Total
NFHS I 1990-1992	22.9	36.0	22.1	19.0	100.0
NFHS II 1996-1998	21.6	38.5	22.0	17.9	100.0

Levels of total fertility are substantially lower and contraceptive practice significantly higher in the Hill region of Uttar Pradesh. On the other hand, fertility levels are the highest and levels of contraceptive practice are the lowest in Rohilkhand and Avadh plains. Fertility decline in Uttar Pradesh appears to be sweeping the state from the northwest and southern bounds, leaving the plains bordering Nepal as the last bastion of high fertility. Multiple regression analysis suggests that fertility levels are lowest in Uttar Pradesh where female literacy is high, women engage in gainful employment, and where there are more female health workers per population. Although fertility levels are relatively high where the Muslim population is sizeable, regression analysis shows that this factor is rendered insignificant when the female employment level is controlled. Thus, the analysis suggests that the female autonomy and the practice of pardha are more fundamental to fertility variation than religion per se.

Fertility Transition in Uttar Pradesh and its Policy Implications

F. Ram, Arvind Pandey, T. K. Roy, Zaheer Khan

Uttar Pradesh is the most populous state in India with about 139 million persons according to the 1991 census. It has almost 17 percent of the total population of India, but only 10 percent of the country's land area. Projections show that the population of Uttar Pradesh would reach 245 million in 2016 from the current population of about 172 million. In view of momentum, the population of the state is not going to stabilize before attaining the size of about 400 million.

This paper examines the onset of fertility transition in Uttar Pradesh and the changes that have taken place thereafter. Regional variations in fertility have also been examined to design area-specific programmes.

Before 1961, TFR in Uttar Pradesh was estimated as 6.3 children per woman. The estimated crude birth rate (CBR) in 1975 was 37 per 1,000 and TFR was 5.4. The corresponding estimate went up to 39 and 5.9, respectively, in 1980. After 1980, however, there seems to be secular decline in fertility, although the pace of change has been very slow. From 1980–1990, the CBR declined by about 9.6 percent and the TFR by 11 percent. The latest SRS data for 1997 indicate the CBR at 33.5 per 1,000 and the estimated TFR at 4.7. Thus, from 1990–1997, the CBR in Uttar Pradesh declined by 5.9 percent and TFR declined by 9.6 percent. Based on trends observed from 1990–1997, it will be very difficult for Uttar Pradesh to achieve a TFR of 2.1 even by 2035.

Based on the analysis of age-specific fertility rates for Uttar Pradesh from the SRS, the change in TFR has been largely due to the decline in fertility of women beyond age 35. There has been little change in the fertility of

women between the ages of 20 and 34. Adolescent fertility has not appreciably declined because the age at marriage has not increased substantially in the state. According to NFHS I, the median age at marriage for females in the age group 20–24 was 16.4, remaining almost the same in NFHS II. Peak fertility remains in the age group 25–29 years, and the current age-specific fertility rate combined with the age distribution is highly conducive to a high birth rate. It may not be possible to accelerate fertility decline in Uttar Pradesh unless there is a rapid decline in the pace of fertility of older women and some changes at younger ages. In view of the higher fertility after age 30, sterilization may still play an important role in the fertility decline of the state.

Comparison of Birth Order Distributions form NFHS I and NFHS II: Uttar Pradesh 1990-1997

Source	Order of Birth				
	1	2-3	4-5	6+	Total
NFHS I 1990-1992	22.9	36.0	22.1	19.0	100.0
NFHS II 1996-1998	21.6	38.5	22.0	17.9	100.0

The estimated TFR in NFHS I was 4.8, which is about 5 percent lower than that of the SRS estimate for 1991. Rural and urban TFR estimates were also lower by almost the same amount. In NFHS II, the estimated TFR was 4.0 for the state as a whole, 4.3 for rural and 2.9 for urban areas, indicating that the TFR in NFHS II is lower by about 18 percent compared to SRS estimates for 1997. In rural areas, the difference is 14 percent, and in urban areas 25 percent. The contraceptive prevalence rate was 18.5 percent in NFHS I, increasing to 22 percent in NFHS II. If all other proximate factors such as age at marriage, lactational infecundability, and induced abortions have remained constant or have changed very little, change in the contraceptive prevalence rate can explain only about 4 percent of the change in TFR from NFHS I to NFHS II.

Fertility differentials by selected characteristics of the population and geographical area can also provide some idea about the fertility dynamics. Illiterate women in Uttar Pradesh still have more than 4.5 children, compared to women who are literate or have completed middle school. There are no significant variation in TFR between the Scheduled Tribes and the Scheduled Castes; however, the general population has much lower fertility. Between 1971–1998, fertility declined by 46 percent in the Hill region because of an appreciable increase in the use of modern contraceptive methods. In other regions, the decline in fertility was not significant.

Discussant

P. M. Kulkarni

The first paper in this session described the trends in fertility decline and the trends in increase in the contraceptive prevalence rate; the other two papers concentrated on fertility estimates, transition, and regional variations in fertility behaviour. Fertility estimates based on retrospective surveys are not very accurate due to displacement of births. Estimates of change in fertility have serious limitations

Age-Specific Fertility Rates from SRS by Age Group and Residence in Uttar Pradesh

Residence/ Age Group	Age Group						
	15–19	20–24	25–29	30–34	35–39	40–44	45–49
1975							
Rural	0.107	0.268	0.281	0.228	0.151	0.067	0.030
Urban	0.083	0.220	0.223	0.178	0.103	0.048	0.017
Total	0.103	0.259	0.269	0.220	0.144	0.064	0.028
1985							
Rural	0.106	0.298	0.288	0.233	0.143	0.074	0.036
Urban	0.055	0.227	0.232	0.165	0.094	0.051	0.027
Total	0.094	0.282	0.276	0.220	0.134	0.071	0.035
1991							
Rural	0.081	0.287	0.270	0.209	0.140	0.071	0.027
Urban	0.038	0.212	0.201	0.150	0.075	0.049	0.016
Total	0.072	0.271	0.255	0.197	0.127	0.067	0.025
1997							
Rural	0.043	0.260	0.281	0.208	0.124	0.066	0.025
Urban	0.025	0.198	0.221	0.152	0.075	0.047	0.014
Total	0.040	0.248	0.271	0.198	0.115	0.062	0.023

Age-Specific Fertility Rates from NFHS I and NFHS II by Place of Residence in Uttar Pradesh

Residence/ Age Group	NFHS I 1990–1992							TFR
	15–19	2–24	25–29	30–34	35–39	40–44	45–49	
Rural	0.128	0.288	0.264	0.195	0.105	0.044	0.014	5.19
Urban	0.062	0.239	0.204	0.125	0.057	0.014	0.013	3.58
Total	0.113	0.278	0.251	0.177	0.094	0.037	0.014	4.82
	NFHS II 1996–1998							
Rural	0.137	0.272	0.218	0.137	0.071	0.020	0.006	4.31
Urban	0.057	0.195	0.173	0.095	0.040	0.012	0.004	2.88
Total	0.120	0.256	0.208	0.127	0.064	0.018	0.006	3.99

because the relative error in estimate of change could be greater than the relative error in the estimate of value. The evidence presented by Bhatt and Ram in the second two papers tried to examine the internal consistency by corroborating with other independent estimates. One aspect that has clearly emerged from these presentations is that there has been a decline in fertility in Uttar Pradesh in the last five years. It is only the quantum of decline that is being debated. Whether TFR is 4 or 4.5 is not important; however, what is important is that it has come down though a TFR of even 4 is very high by modern standards. A large number of Indian states have a TFR well below 3, and many are close to 2.

Improvement in the quality of service, access to service, and strategies to meet unmet demand would have an impact on fertility decline. Is it possible to bring about changes in fertility without changes in the desired number of children? This question needs to be addressed. Demographic theories have pointed out that fertility declines to replacement level when there is broad-based development. But in societies that have not experienced broad-based development, fertility has declined when there are ideational changes. Fertility regulation becomes the idea of upper income groups first, then percolates down to the middle and lower income groups later.

Information available on Uttar Pradesh has to be examined along these lines. Even upper income groups in Uttar Pradesh have not accepted the two-child norm. Highly educated, urban, and upper caste families still have fertility well above a TFR of 2. Some other studies also have shown that the diffusion process in Uttar Pradesh is slow. Even if the upper income groups reach replacement level fertility, the time it takes for low-income groups to adopt the same norm is expected to be longer in Uttar Pradesh compared to other states. Diffusion takes place at a faster pace when there is a strong desire for social mobility in a substantial proportion of the population. In sum, there has been a decline in fertility, but it has not been adequate. If the present trend continues, it may take a long time to reach replacement level fertility. Programme interventions are useful but what is probably more important is that there would have to be major changes in social and economic conditions.

Discussant

T. K. Roy

The preliminary report of NFHS II estimates the TFR at four children, a decline of 17 per cent compared to TFR of 4.8 estimated in NFHS I in 1992. NFHS II was conducted in 333 primary sample units and covered 8,682 households. In these households, 9,292 eligible women were interviewed. The preliminary findings showed a decline in fertility. The total fertility rate in urban areas declined from 3.58 in 1992 to 2.88 in 1997 and in rural areas from 5.19 to 4.31. The decline in fertility, when it takes place, may not be uniform. The decline may be faster from four children to three, but is likely to be slow and difficult to reach two children from three. There are several intervening factors that act as major obstacles. One of the significant factors is the preference for male children. Even among educated women in Uttar Pradesh, the "son preference" is very high.

There has been substantial increase in traditional method use among illiterate women between NFHS I and NFHS II; however, there is no information available on how effective these methods are. Similarly, no information is available on the extent of induced abortion and the role played by induced abortions in fertility decline. Comparative analysis of NFHS I and NFHS II data has shown a considerable increase in the proportion of literate women and an increase in levels of education. This will undoubtedly help the programme in achieving further rapid decline in fertility.

SESSION II

CONTRACEPTIVE USE AND BEHAVIOUR

Chairperson: *Gautam Basu*

Contraceptive Use in Uttar Pradesh: Recent Evidence and Policy/Programme Implications

T. K. Roy, Ravi K. Verma, Arvind Pandey

Contraceptive Use and Sources of Supplies in Uttar Pradesh

K. M. Sathyanarayana and Gadde Narayana

Discussants: *Tara Kanitkar and Sumati Kulkarni*

Session II

Contraceptive Use and Behaviour

The contraceptive prevalence rate in Uttar Pradesh is very low, and several factors have contributed to this. It is also very important to increase the contraceptive prevalence rate to achieve replacement level fertility. It is necessary to understand the profiles of users and non-users of contraceptive methods and trends in contraceptive use during a period of time. It is equally important to understand the effects of innovative projects introduced as part of the Innovations in Family Planning Services (IFPS) Project in selected districts of Uttar Pradesh. This understanding will provide information on the type of interventions needed to improve overall performance levels in the state.

Remarks of the Chairperson

Gautam Basu

The contraceptive prevalence rate has been increasing in the state of Uttar Pradesh. There may be some debate on the pace of increase over time, but there is no dispute that the contraceptive prevalence rate has been increasing. The two papers included in this session throw light on trends in the rate in Uttar Pradesh, factors that determine contraceptive use and results of important interventions introduced by the IFPS Project implemented by the State Innovations in Family Planning Services Agency (SIFPSA).

Contraceptive use in Uttar Pradesh: Recent Evidence and Policy/Programme Implications

T. K. Roy, Ravi K.Verma, Arvind Pandey

With a population of more than 140 million and a growth rate of more than 2.2 percent, Uttar Pradesh is considered one of the most demographically backward states in India. The TFR of 4 continues to present a serious challenge to the family planning programme. Contraceptive use estimates available from various sources, such as the NFHS I in 1992–1993 and NFHS II in 1998–1999, the rapid household surveys, and the PERFORM survey, provide evidence of the direction in which the state's family planning programme is moving and the emerging challenges that the programme has to address. This paper

discusses the issues related to the low and only marginal increase in the use of modern contraceptives in the past decade, wide regional and rural/urban differences, low reach and poor quality of services, and the continued resistance to family planning.

According to the NFHS II, 28 percent of currently married women ages 15–49 are using a method of contraception. Modern contraceptive use is 22 percent. Female sterilization is the most popular contraceptive method, used by 15 percent of currently married women. In the six years between NFHS I and NFHS II, there has been an increase of only 3 percentage points in the current use of modern contraceptive methods in Uttar Pradesh, due in large part to the increase in female sterilization. In fact, male sterilization has registered a slight decline, whereas use of the pill, IUCDs, and condoms has remained by and large stagnant.

The low contraceptive practice in the state is not entirely due to the poor demand for family planning. Significantly, a major increase in contraceptive use was in the use of traditional methods. A substantial number of women in rural areas (5.7 percent) reportedly used traditional methods at the time of NFHS II, compared to only about 1 percent of rural women during NFHS I. Use of periodic abstinence as a method of fertility regulation increased substantially between the two surveys.

Contraceptive Prevalence Rate in Uttar Pradesh: 1992-1993 and 1998-1999

Method	1992-93		1998-99	
	Percent Ever Used	Percent Currently Using	Percent Ever Used	Percent Currently Using
Any Method	26.1	19.8	37.6	28.1
Any Modern Method	23.4	18.5	30.1	22.0
Pill	4.3	1.0	7.3	1.2
IUCD	3.1	1.1	3.9	1.0
Condom	6.4	3.2	9.6	4.2
Female Sterilization	11.7	11.7	14.9	14.9
Male Sterilization	1.4	1.4	0.7	0.7
Traditional Methods	4.5	1.3	11.8	5.7
Periodic Abstinence	3.5	0.9	9.2	4.1
Withdrawal	1.2	0.2	4.4	1.6
Other Methods	0.5	0.1	0.8	0.4
Total Women	11,014	11,014	8,918	8,918

There exists a significant rural/urban difference in the use of modern contraceptive methods. During 1998–1999, about 37 percent of women were using modern contraceptives in urban Uttar Pradesh, whereas only 18 percent were using them in rural areas. The contraceptive prevalence rate for any method is about twice the rate in rural areas. The contraceptive prevalence rate for any method has increased from 32 to 45 percent in urban areas and from 17 to 24 percent in rural areas. For modern methods, the increase is very low in both urban and rural areas.

Use of any modern method is highest in the Hill region (44 percent), followed by the Bundelkhand region (34 percent). The other three regions (Western, Central, and Eastern) have almost the same contraceptive prevalence rate. The social, economic, and demographic characteristics of acceptors follow an expected pattern. The use of contraceptives increases steadily with an increase in the educational level of women. While 2 percent of women with no living children are current users of contraceptives, 39 percent with more than three children use contraceptives. Although the prevalence of contraceptive use has been higher among Hindu than Muslim women, the rate has improved among both groups. Contraceptive

Reasons for Not Intending to Use FP Methods in Future by Non-users of Methods According to Age in Uttar Pradesh: 1998-99

Reasons for not Intending to use	Age		Total
	<30 years	30+ years	
1. Fertility-related reasons	34.1	59.0	49.9
2. Oppositions to use	28.1	15.9	20.4
* Husband	6.5	4.2	5.0
* Religion	17.7	8.2	11.7
3. Lack of knowledge	9.3	3.5	5.7
4. Method-related reasons	21.0	17.0	18.5
* Do not like methods	9.5	8.2	8.7
* Worry about methods	6.4	4.3	5.1

Contraceptive Prevalence Rate by Regions in Uttar Pradesh : 1992-1993 and 1998-1999

	1992-1993			1998-99		
Regions	**Any Modern Method**	**Any Spacing Method**	**Sterilization**	**Any Modern Method**	**Any Spacing Method**	**Sterilization**
Hills	34.5	4.3	30.2	41.4	9.6	31.8
Western	17.4	7.1	10.3	22.5	8.2	14.2
Southern	14.6	4.3	10.3	21.2	8.9	12.3
Eastern	14.6	2.8	11.8	18.6	3.6	15.0
Bundelkhand	27.7	5.2	22.5	30.4	3.0	27.5

use among Hindu women increased from 21 percent in NFHS I to 29 percent in NFHS II. Similarly among Muslim women, the use increased from 11 percent in NFHS I to 21 percent in NFHS II. An insignificant proportion of current users (13 percent) were motivated by the workers of family welfare department. The practice of home visits by ANMs is almost non-existent. Only 3 percent of women reported to have received a home visit by a worker in 12 months preceding NFHS II.

The proportion not intending to use family planning in the future has declined recently. According to NFHS I, three out of five women mentioned that they did not intend to use family planning in the future. During NFHS II, only two out of five women did not intend to use family planning in the future. Opposition factors from husbands, method-related apprehensions, and religion are the major reasons for not intending to use contraceptive methods. There has been a decline in the desire for children; however, the declining desire for children and the increase in knowledge are affecting greater use of family planning methods. For the family planning programme to succeed in Uttar Pradesh, the reach of services will have to be strengthened. In addition, involving men in family planning to limit opposition to contraceptive use should be addressed.

Contraceptive use and Sources of Supply in Uttar Pradesh

K. M. Sathyanaryana and G. Narayana

Contraceptive use is one of the most important proximate determinants influencing the fertility behaviour of a population. The use of modern methods of contraception in Uttar Pradesh increased from 2 percent in 1951 to 22 percent in 1999. The IFPS Project randomly selected 28 districts of Uttar Pradesh to introduce several innovative approaches to improve access, quality, and demand aspects of the family planning programme. The innovative projects, covering both public and private sectors, were implemented in 15 districts in the first phase. The purpose of this paper is to examine the extent of changes in contraceptive use, method mix, and sources of supplies in 28 IFPS districts, and also compare the changes in 15 priority districts

Currently Married Women in Reproductive Age (15–49) Using Contraceptive Methods in 28 Districts of Uttar Pradesh

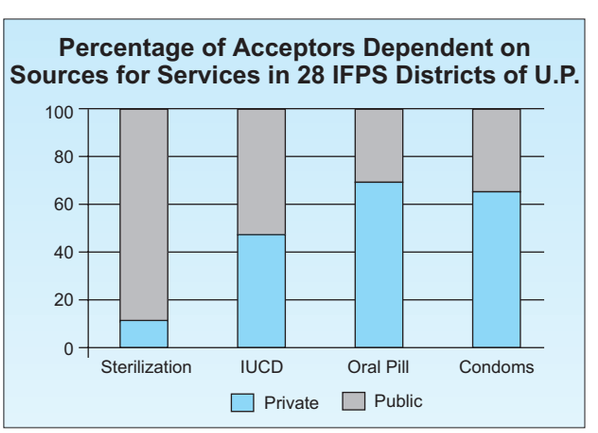
		PERFORM 1995			SO2 Indicator Survey (1999)		
	Family Planning Methods	**Priority Districts**	**Other Districts**	**Total**	**Priority Districts**	**Other Districts**	**Total**
1	Sterilization	16.2	14.5	15.0	18.6	14.9	17.2
2	IUCD	1.3	1.2	1.2	1.4	1.1	1.3
3	Oral Pills	1.7	1.3	1.6	2.3	1.9	2.1
4	Condoms	3.2	3.0	3.1	5.2	2.8	4.3
	All Modern Methods	22.4	20.0	20.9	27.5	20.7	24.9

where innovative approaches were introduced and 13 other districts with no additional inputs. The PERFORM Survey conducted in 28 districts and the SO2 Indicator Survey conducted in 1999 formed the basis for analysis.

The modern contraceptive use in 28 IFPS districts increased by 4 percentage points from 20.9 percent in 1995 to 24.9 percent in 1999. Increases in contraceptive use in 1999 compared to 1995 were largely due to increases in the use of sterilization, oral pills, and condoms, while the use of IUCDs remained about the same. In 1995, the contraceptive prevalence rate was 22.4 percent in priority districts and 20 percent in other districts. According to the SO2 Indicator Survey, the contraceptive prevalence rate in 1999 was 27.5 percent in priority districts and 20.7 percent in other districts. Differences in modern contraceptive use widened in the past 4.5 years between priority and other districts, from 2.4 percentage points in 1995 to 6.8 percentage points in 1999. The contraceptive prevalence rate remained stagnant in other districts.

Method mix among modern contraceptive method users improved between 1995 and 1999 in favour of supply methods such as oral pills and condoms. Oral pill users formed 8 percent of total current users in 1995, and this proportion increased to 9 percent in 1999. There has been a substantial increase in the proportion of condom users from 15 percent of total current users in 1995 to 17 percent in 1999. The use of supply methods increased from 23 to 27 percent. In priority districts, the proportion of users of supply methods to total current users increased from 29 percent in 1995 to 33 percent in 1999, while in other districts, spacing method users remained the same at 28 percent. The shift in method mix could be largely due to NGO and cooperative projects implemented in priority districts with emphasis on promotion of spacing methods.

In terms of method mix, nearly three-fourths of women obtained services from the public sector in 1995. Only 9 percent used the private sector and 14 percent used the commercial sector. Sterilization (90 percent) and IUCD (62 percent) were obtained from the public sector, while the commercial sector accounted for 60 percent of oral pill users and 70 percent of condom users. The public sector has remained the predominant source. However, the share of private and marketing sectors has increased considerably for all modern contraceptive methods compared to 1995, particularly for oral pill and IUCD users. This trend is true for priority and other districts. Nevertheless, a clear trend of preference for the private sector is emerging whether it is a priority or other districts. The majority of current users of oral pills and condoms are new to these methods, and the continuation rates are better in priority districts than others.



There has been a perceptible increase in use of modern contraceptives in 15 priority districts where SIFPSA has introduced several innovative projects to improve access, demand and quality of service delivery systems. This clearly indicates that the innovations have started yielding positive results.

Spacing method use has increased considerably in priority districts during this period. SIFPSA funded NGO projects with community based volunteers have considerably contributed to this increase in spacing method use.

Care of pregnant women increased substantially during this period in both priority districts and other districts. This was mainly due to the special campaign conducted by the Health and Family Department in 1999. The campaign yielded positive results. The increase in ante-natal care services and TT injections given to pregnant women was largely due to contacts made by ANMs during the special campaign. Since the campaign covered all 28 districts, the differences between 15 priority districts and other districts was negligible. Special campaigns particularly to provide services to pregnant women have to be carried out every year. This will substantially change the health care seeking behaviour of women in rural areas.

There is a need to rapidly expand innovative approaches to the remaining 13 districts to improve overall performance in 28 IFPS districts.

Discussant

Tara Kanitkar

When we started analyzing the NFHS I data in 1993, we were perplexed by the fact that only 20 percent of women in Uttar Pradesh were modern method users. In 1999, this proportion increased to 22 percent. However, there was a considerable increase in traditional method use among illiterate women in Uttar Pradesh for two reasons: either illiterate women there did not properly understand the question or lacked access to spacing methods. This fact requires further examination.

There is considerable emphasis placed on spacing methods, but sterilization methods deserve equal importance, particularly because women with high parity have not been using any method. Spacing methods should be promoted only among newly married couples and couples with one child. For others, sterilization should be promoted, particularly male sterilization.

Another important point is resistance to family planning. Opposition to the use of family planning methods derives mostly from male family members. Information, education and communication (IEC) efforts, therefore, should concentrate on changing the attitudes of men. Muslims use condoms for religious reasons. The programme should encourage this while promoting spacing methods among Muslims. A large number of family planning acceptors seek the private sector and not the public sector for follow-up services. Public sector managers should critically examine their own performance and determine why clients prefer the private sector for these services. In addition, Dr. Roy's paper does not mention anything about "son preference" in Uttar Pradesh.

In regard to the second paper, more clarity is

required, particularly to the differences between priority districts and other districts. Performance declined after introduction of the Target-free Approach (TFA) in the first year, but continued implementation of TFA resulted in improved performance.

Discussant

Sumati Kulkarni

There was considerable discussion on unmet need for family planning in Uttar Pradesh after NFHS I. Nearly 30 percent of women have unmet need for family planning. Even without changing their desired family size, if women in Uttar Pradesh are helped to translate their desires into actions, Uttar Pradesh fertility would decline by 28 percent. It is important for us to know whether that process has started. The two papers presented in this session offer clues as to what is happening to the family planning programme in Uttar Pradesh and whether SIFPSA-sponsored interventions are working. We have to look at the family planning programme from several points of view: What are the encouraging signs? What are the areas of concern? What are the perplexing aspects of programme performance?

Unmet need for family planning in Uttar Pradesh has increased over time. There is potential demand, but this can not be taken at face value. There are several constraints faced by intending users at the family and service delivery levels. Another way of looking at the contraceptive-use behaviour is resistance to using family planning methods. Factors that lead to resistance should be clearly understood in order to develop appropriate service delivery strategies. There are also other development factors that influence use of contraceptives. In Uttar Pradesh, the percentage of illiterate women declined by 6 percentage points in the last six years while the percentage of women with above secondary education increased marginally. The percentage of non-working women declined from 87 to 77 percent, and the age of marriage has not changed even in urban areas. But contraceptive method use increased from 20 percent in 1995 to 28 percent in 1999, mainly because of the increase in the use of traditional methods.

In traditional societies, methods that require cooperation from husbands increased considerably, particularly among illiterate women. However, the problem is that the women are adopting less effective methods. Many southern states emphasized sterilization and achieved replacement level fertility. If Uttar Pradesh wants to emphasize spacing methods, more significance should be given to access to services. Are auxiliary nurse/midwives (ANMs) in Uttar Pradesh in a position to insert IUCDs at subcentres as has been the case with Maharashtra? Just improving the knowledge about methods is not enough. Service delivery strategies should address several constraints faced by women.

The gap between priority and other districts has widened over time. It is, therefore, necessary to closely examine what interventions contributed to the increase in contraceptive use in priority districts. This analysis should concentrate on the cost-effectiveness of interventions as well.

SESSION III

REPRODUCTIVE AND CHILD HEALTH SERVICES IN UTTAR PRADESH

Chairperson: *Saroj Pachauri*

HIV/AIDS Programme in India and Uttar Pradesh
Subhash Salunke

Reproductive Tract Infections: Programme Implications
Subhash Hira

Special Campaigns for Maternal and Child Health Services: Innovative Approaches in Uttar Pradesh
Aradhana Johri

Maternal and Child Health Care in Uttar Pradesh
Kamala Gupta

Discussants: *Cristina Arismendy and M. C. Gupta*

Session III

Reproductive and Child Health Services in Uttar Pradesh

India integrated family planning services with that of MCH services in the 1970s by converting uni-purpose worker programmes to multi-purpose programmes. Further support for this shift came after the 1994 International Conference on Population and Development (ICPD). Achievement of the objectives of population stabilization depends on infant and maternal mortality rates. Added to this are the problems of HIV and reproductive tract infections (RTIs). This session deals with the impending threat of AIDS, the management of RTIs, the status of MCH services, and innovative approaches that showed promise of improving MCH care and use of modern contraceptives.

Remarks of the Chairperson

Saroj Pachauri

We are now going to broaden the agenda and move from the context before us this morning of fertility trends and behaviour. We have discussed a whole host of issues related to contraceptive prevalence rates and behaviour. This session deals with broader reproductive health concerns, which include MCH issues, sexually transmitted diseases (STDs), HIV and AIDS.

AIDS Programme in India and Uttar Pradesh

Subhash Salunke

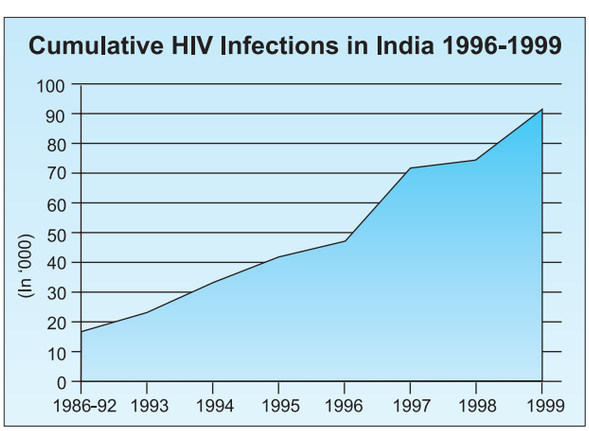
The first case of human immuno-deficiency virus (HIV) infection and acquired immuno-deficiency syndrome (AIDS) in India was reported in 1986. Since then, the disease has spread to all states in the country. However, the spread of the virus has not been uniform. The epidemiological, socioeconomic, and cultural factors play a key role in the differential spread of the epidemic. Most of the infected and diseased individuals are reported from the urban areas of the states of Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, and the northeastern state of Manipur.

The Indian Council of Medical Research initiated the sero-surveillance in India in 1984. Since then as per the sero-surveillance reports available to the National AIDS Control Organization (NACO), a cumulative total of 3.57 million samples have been tested for HIV, out of which 92,321 samples were found

sero-positive by December 1999. The sero-positivity rate works out to 25.8 per 1,000. A cumulative total of 9,966 AIDS cases were reported in India during this period; however, as the reporting of HIV-infected individuals and AIDS cases is far from satisfactory, these figures represent the proverbial "tip of the iceberg," or "tip of the tip of the iceberg."

The NACO initiated sentinel surveillance in India in 1994. Initially, 55 sentinel sites were established throughout the country. Data collected from these sites were representative of high-risk and low-risk behaviour groups. For many reasons, it was difficult to draw conclusions from the data available until 1998. After expanding the sentinel sites, NACO organized a National Sentinel Survey in 180 sentinel sites throughout the country in 1999. Based on the available data, NACO acknowledged the magnitude of the epidemic and estimated that India had about 3.5 million HIV and AIDS cases by mid-1998. The highest numbers of HIV-infected individuals were from Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, and Manipur.

The major mode of transmission of HIV infection is through the heterosexual route



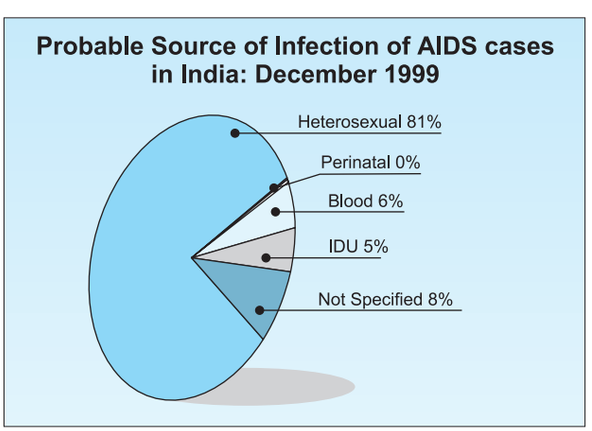
(80 percent), followed by blood transmission, and use of injectable drugs. Of the total number living with HIV and AIDS, 79 percent are males and 21 percent are females. A vast majority of them are between the ages of 15 and 49. Trends also indicate that HIV infection is spreading in two ways: from urban to rural areas and from individuals practicing high-risk behaviours to the general population. The major opportunistic infection in AIDS patients is tuberculosis. India, therefore, may face the dual epidemic of tuberculosis and AIDS.

In 1987, the National AIDS Control Programme (NACP) was launched. The main focus of activities during its initial phase was increasing awareness of HIV/AIDS, screening of blood for HIV at blood banks, and testing of individuals practicing risky behaviour. In response to the growing challenge of HIV/AIDS, the Government of India drafted a Medium-term Plan (1990–1992) in collaboration with the World Health Organization. This plan focused on the most affected states and cities in the country. Mumbai, Chennai, Calcutta, Delhi, and Manipur were selected as part of this effort. The Medium-term Plan emphasized strengthening programme management capacity, initiating targeted IEC campaigns and surveillance. With the assistance of donor agencies, particularly the World Bank, the Government of India, after preparing a strategic plan for the prevention and control of AIDS, launched the National AIDS Control Project in 1992 at an estimated cost of Rs 2,266 million. The project's main objective was to slow the spread of HIV in India in order to reduce the morbidity, mortality, and impact of AIDS. The major components of the programme were as follows:

- Strengthening the management capacity for HIV control
- Building surveillance and clinical management capacity
- Promoting public awareness and community support
- Improving blood safety and rational use
- Controlling STDs

In spite of many achievements, the NACP could not achieve some of its main objectives. Because of administrative reasons and lack of advocacy, AIDS control activities were not accorded sufficient priority by many states. The NACP was seen as the central Government programme and, as a result, ownership of the programme was lacking. In some states, even essential activities, such as conducting the sentinel surveillance and modernizing blood banks within the stipulated period, were not carried out. The AIDS cell at the state level was not effective because of the large number of vacant positions.

The social stigma of sexually transmitted infections (STIs) also exists for HIV/AIDS, albeit in a much more serious form. There have been reported cases of refusal of admission of AIDS patients in both public hospitals and private nursing homes. More often, the isolation of AIDS patients in hospitals contributes to the notion that AIDS is a contagious disease. In the work place, there have been instances of discrimination leading to dismissal.



After assessment of the achievements and shortcomings of Phase I of the National AIDS Control Project, the Government of India designed and launched Phase II. The main objectives of the phase were to reduce the spread of HIV; strengthen India's capacity to respond to HIV/AIDS over the long term; reduce HIV transmission among the poor and marginalised sections of the community at the highest risk of infection; reduce the spread of HIV among the general population, which is perceived to be at a lower risk; develop capacity for community-based, low-cost care; strengthen the institutions responsible for programme implementation; and forge intersectoral collaboration among public, private, and voluntary sectors for a broad-based response to the epidemic.

Uttar Pradesh is the most populous state in India with a population of about 170 million. Uttar Pradesh has its links with the city of Mumbai because many young people, particularly from rural areas, go to Mumbai to earn a livelihood. Many of these young migrants stay alone in Mumbai, returning to their families once or twice a year. Risk factors of acquiring STD/HIV among these migrants are high. Thus, with the high-incidence prevalence of HIV/AIDS in Mumbai, many workers from Uttar Pradesh acquire STD/HIV in Mumbai and pass it on to their spouses.

The first case of AIDS in Uttar Pradesh was detected in 1987. The AIDS programme in the

Sero-Surveillance for HIV Infection, HIV Positive Cases, and AIDS Cases up to December 1999

S. No	Name	Screened	Positive	Sero-positivity Rate Per 1,000	AIDS Cases
1	Andhra Pradesh	74,566	704	9.44	48
2	Assam	16,356	244	14.92	33
3	Arunachal Pradesh	495	0	0.0	0
4	A&N Islands	15,290	129	8.44	0
5	Bihar	10,194	41	4.02	3
6	Chandigarh	56,720	265	4.67	124
7	Delhi	325,803	1,398	4.29	219
8	Daman and Diu	250	8	32.0	1
9	Dadra & Nagar Haveli	160	1	6.25	0
10	Goa	70,673	2,237	31.65	19
11	Gujarat	454,372	1,767	3.89	137
12	Haryana	167,385	600	3.58	1
13	Himachal Pradesh	5,852	128	21.87	25
14	Jammu & Kashmir	8,981	40	4.45	2
15	Karnataka	412,782	5,511	13.35	204
16	Kerala	44,547	215	4.83	106
17	Lakshadweep	1,211	8	6.61	0
18	Madhya Pradesh	111,692	937	8.39	326
19	Maharashtra	438,799	49,870	113.65	3,379
20	Orissa	83,127	217	2.61	2
21	Nagaland	8,852	449	50.72	29
22	Manipur	40,744	6,325	155.24	362
23	Mizoram	39,985	133	3.33	12
24	Meghalaya	14,250	60	4.21	8
25	Pondicherry	92,896	3,479	37.45	141
26	Punjab	1,523	65	42.68	100
27	Rajasthan	23,044	554	24.04	106
28	Sikkim	602	11	18.27	2
29	Tamil Nadu	762,426	14,750	19.35	4,354
30	Tripura	5,613	4	0.71	0
31	Uttar Pradesh	118,963	1,513	12.72	166
32	West Bengal	163,991	649	3.96	57
	Total	3,572,144	92,312	25.84	9,966

state was launched in 1992–93. The state presently has five sentinel and clinical management centres, in which 105,933 persons of high-risk groups have been screened. Of these, 1,237 have tested HIV positive, thereby producing a sero-positivity rate of 11.6 per 1,000. The sero-positivity rate among STD clinic attendees is 2.2 percent and among antenatal care (ANC) attendees 0.2 percent. Compared to many other states, the sero-positivity rate in Uttar Pradesh is very low; however, all factors that lead to the spread of HIV in both rural and urban areas are present in Uttar Pradesh.

Reproductive Tract Infections: Programme Implications

Subhash Hira

The control of sexually transmitted infections (STIs) is critical to global improvement of the reproductive health. While both men and women are affected, women and children bear a disproportionate burden of morbidity and mortality because of these infections. Currently, STIs rank among the five most important causes of years of healthy life lost in developing countries. The list of pathogens causing STIs continues to increase with the emergence of AIDS.

Unrestrained population growth and urbanization has led to the emergence of new STI pathogens and newer syndromes. Improved diagnostic methods have also led to easier identification of pathogens, such as HIV, Hepatitis B and C, and human papilloma viruses. The World Health Organization estimates for 1995 suggested that India has 20–40 million new cases of curable STIs each year. Several hospital-based studies show that between 5 and 10 percent of outpatient care at major hospitals involves STIs. However, there are not many systematically conducted community-based studies.

The rate of spread of STIs is determined by three factors: (1) the rate of exposure of susceptible people to infected people; (2) the probability of transmission of the infection; and (3) the time that the infected person remains infectious. Interventions for RTI/STI within a population aim at strategies to reduce the rate of exposure to RTI/STI by reducing the rate of partner change; reducing the efficiency of transmission; and shortening the duration of infectiousness by early detection and treatment of STI/RTI. The implementation of these strategies requires both behavioural and biomedical interventions. In fact, both behavioural and biomedical approaches are complementary and inter-dependent. Neither can work in isolation.

It is also important to realize that reducing the exposure, efficiency of transmission, or duration of infectiousness to zero will not eliminate STI transmission altogether. Focusing on one strategy to the exclusion of others is likely to reduce gains in intervention. Conversely, equal allocation of resources to each of these three targets is neither feasible in any setting nor necessarily the most cost-effective approach. The practical approach will be a balanced effort in which resources are increasingly committed to each of the three potential points of intervention. The practical approach requires:

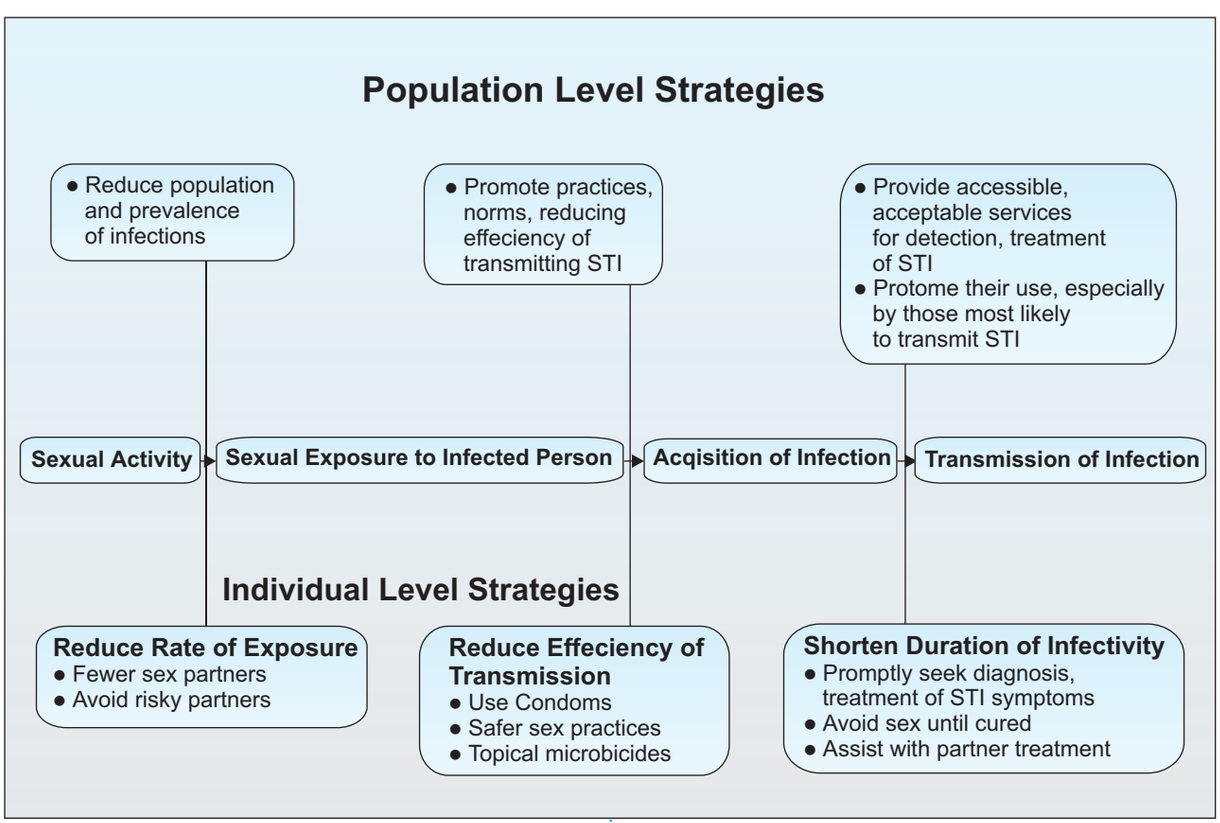
- **Reducing exposure to RTI/STI.** Behavioural interventions can be designed to delay the onset of sexual activity among

youth, decrease rates of new sex partner acquisition, encourage choice of a safe sexual partner, and popularize faithful monogamy.

- **Reducing the efficiency of STI transmission.** Interventions can include promoting the delay in initiation of sex by females because younger rather than older women are anatomically more susceptible to acquiring certain endo-cervical infections.
- **Reducing the duration of infectiousness.** Interventions should include easily accessible, acceptable, and effective services for early detection and treatment of STI/RTI. Curative treatment of RTI/STI can only reduce transmission of those specific curable diseases. However, combined interventions that reduce risky sexual behaviours or result in increased condom use that can prevent most, if not all, important RTIs/STIs.

Normally, the number of people in a community who have or are at risk of STI is much higher than the numbers who actually visit health institutions and are cured. Consequently, curative services alone contribute only a small fraction to STI control and consequent reduction in their adverse effects. The strategy of providing curative services alone will not solve the problems.

It is therefore important that RTI/STI programmes begin to provide interventions at the top of the preceding diagram to reduce



risk through educational efforts, make more condoms available, do case findings through partners, and provide screening of pregnant women for syphilis. The synergy of efforts in this direction—prevention and case finding—in addition to improved STI case management, will be the most effective approach to STI control. Once a community is educated and motivated to seek treatment for STI, there will be more pressure on clinical services to meet its demands. And once clinical services are user friendly and effective, more members of the community will utilize them.

Special Campaign for Maternal and Child Health Services: Innovative Approach in Uttar Pradesh

Aradhana Johri

Realizing the importance of bringing down the maternal and infant and child mortality rates and the subsequent affect on fertility, the Government of India initiated various programmes and projects. In spite of enormous efforts made to this point, the programme has not been able to create the desired impact either at national or state levels. Uttar Pradesh is no exception. Use of reproductive and child health services, for various reasons, is very low in the state. Less than one-half of pregnant women received antenatal care; slightly more than two-thirds received two doses of tetanus toxoid (TT) injections; and 30 percent received iron and folic acid (IFA) tablets. Only 11 percent of births occurred in health institutions while trained individuals attended a large proportion of births. For these reasons, maternal and child mortality rates are still high. Given this, SIFPSA, taking into consideration the Government of India's new agenda, decided to integrate family planning and MCH by initiating innovative activities to improve the family planning and reproductive and child health indicators in the state. Reproductive and child health camps, statewide special campaigns for TT vaccination for pregnant mothers, and the *Parivar Swasthya Jagrukta* campaign (campaign to create awareness among people) were conceived. This paper deals with processes and experiences of conducting these campaigns in the state.

Integrated Reproductive and Child Health Camps. To provide integrated reproductive and child health services, the SIFPSA developed the reproductive and child health (RCH) camps to provide integrated MCH and family planning services. In each camp, gynecological checkups, child examinations and immunizations, and family planning counseling and services are provided In February 1998, SIFPSA decided to experiment with RCH camps, popularly known as *Parivar Swasthya Seva Divas,* in 29 IFPS districts of Uttar Pradesh. Before designing a camp approach, the following series of process-related issues were closely examined and choices made and incorporated:

- What type of RCH services should be provided?
- Who should provide them?
- What equipment and instruments are needed?
- How should the RCH camps and their services be publicized?
- What logistical support will be needed?
- How often should the camps be conducted?
- Who should monitor the quality of the camps?

- What will be the budgetary requirement?

Organization of each camp involved detailed planning relating to publicity, manpower deployment, camp arrangements, post-camp services including transportation, availability of consumables, and medical equipment. Each camp was scheduled in advance and publicized through advertisements in local newspapers. Specially designed banners and handbills were prepared to promote the RCH camps as *Parivar Swasthya Seva Divas,* or family health day. In rural areas, playing attractive jingles on audiocassettes carried around in hired rickshaws created awareness about the camps. Between May and September (considered the lean period), one camp was conducted in each block, and two camps per month were conducted during the peak season from October–March. A total of 13,000 camps were conducted during a two-year period. In these camps, 95,994 pregnant women and 119,825 children were provided services. The integrated approach to providing RCH and family planning services also turned out to be more cost effective and convenient for clients.

Special TT Vaccination Campaign. The idea of conducting a TT campaign was discussed by SIFPSA as an accelerated strategy for reducing maternal and child mortality in Uttar Pradesh. Through advocacy, SIFPSA motivated the state health and family welfare department to organize the TT campaign in 1999 in two phases, thus covering all pregnant women throughout the state. In addition to TT injections, IFA tablets and oral rehydration salt (ORS) packets were distributed.

Number of Women and Children Who Availed Services in RCH Camps

Total Camps	13,000
Checkup of Pregnant Women	95,994
Immunization of Pregnant Women (TT Injections)	73,462
Immunization of Children	119,825
Check up by lady doctor	63,437

Special surveys were conducted in villages using the child survival and safe motherhood (CSSM) formats, and all pregnant women were identified. After this, a large-scale IEC campaign was launched, which included electronic media such as TV and radio. In order to get inputs for designing the campaign, a workshop was organized on March 8, 1999, in which service providers of all levels participated. Timing of the campaign, target segment, listing of pregnant women for vaccination, time of day during which vaccination services would be provided at booths and door-to-door, the system of carrying vaccines to the field and re-supplying from primary health centres (PHCs), and reporting related matters and logistics relating to the supply of syringes and needles, ice packs, pressure cooker sterilizers, cotton wool, kerosene, and spirits were discussed. The meeting also identified the materials readily available and the additional resources required at service delivery points. Following this, special meetings were conducted with the District Magistrate to elicit cooperation from other departments.

The TT campaign could generate awareness among the people and improve the coverage

Percentage of Pregnant Women given TT Injections in 1998 and 1999

	SO 1 Indicator Survey: 1998	SO 2 Indicator Survey: 1999
TT Injection Taken		
Yes	45.9	68.1
No	54.1	31.9
Total	100.0	100.0
Number of TT Injections		
One	5.4	9.0
Two	30.7	43.4
Three or More	9.8	15.6
Total Given	45.9	68.0

rates. The Population Resource Centre (PRC) of Lucknow evaluated the results of the campaign by conducting a coverage survey. The PRC, using the cluster sampling technique, identified and interviewed 1,023 pregnant women from 100 clusters in five selected districts. Findings of the survey indicated that before the campaign, 31 percent of pregnant women received only one dose of TT vaccine and 13 percent received two or more doses. Because of the campaign, however, the coverage rate grew to 60 percent of pregnant women for the first dose of TT vaccine and 33 percent for two doses of TT vaccine. The SO2 Indicator Survey, conducted by the POLICY Project in January 1999, had similar findings. Of the total number of pregnant women, 68 percent received TT injections in 1999 compared to 46 percent in 1998. The proportion of women given TT injections increased from 41 percent in 1998 to 59 percent in 1999.

Parivar Swasthya Jagruktha Sapthah. As part of its efforts to generate demand for RCH services and family planning, SIFPSA launched the multi-media campaign in 1998–1999, which used electronic media, print media, folk media, and interpersonal communication to reach couples in rural areas in 15 Phase I districts of the IFPS Project. Workers went from door to door spreading the message that spacing leads to better health. To further strengthen these messages through inter-personnel communication, a mass contact programme was launched using about 6,000 NGO & milk cooperative workers in 14 districts. The campaign's primary objective was to create awareness among potential clients and emphasize the following three messages: spacing leads to better health of mother and child; couples can decide when to have a child; and adoption of family planning leads to a healthy family.

In all, 126 meetings were conducted, and 5,789 community-based distribution workers from Non-Governmental Organization (NGO) and cooperative projects attended these meetings. Workers visited 385,562 women, an average of 56 women per worker, and communicated the three messages. A total of 13,000 group meetings were held in villages for couples and local leaders. Doordarshan and local cable TV channels were used to spread the messages. As a result of this campaign, a large number of potential clients could be contacted and the theme and essence of the messages could be communicated in a short period of time.

The three innovations have clearly demonstrated that significant results can be achieved with limited resources in a short

period of time. Given the status of the service delivery infrastructure, the campaign approach is an effective method of reaching out to remote areas. Campaigns help in bridging the gaps in both demand and supply and are efficient uses of scarce resources.

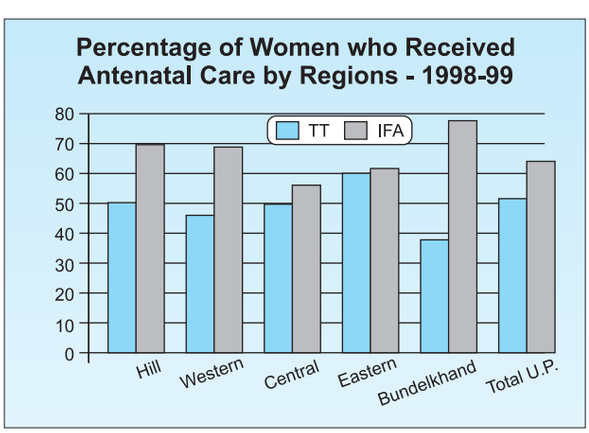
Maternal and Child Health Care in Uttar Pradesh

Kamala Gupta

Maternal and child health care refers to the physical, mental and emotional health of women immediately before, during and after childbirth and health of infants and young children. The MCH services include antenatal, intranatal and postnatal services for mothers and health and nutritional services for infants and children under five. The importance of safe motherhood practices and child survival can not be exaggerated for Uttar Pradesh, where maternal, infant and child mortality rates still continue to be high. According to the latest SRS estimates, Uttar Pradesh had the highest maternal mortality rate in 1997 (707 per 100,000 live births) among all the major states of India. The infant mortality rate is also very high (85 as per SRS estimate for the 1995–1997 period). This paper discusses different aspects of the MCH care in Uttar Pradesh using data collected in NFHS II.

Antenatal Checkups. There has been a decline in the proportion of pregnant women who received antenatal checkups from 47 percent in NFHS I (1992–1993) to 35 percent in NFHS II (1998–1999). Nearly one-fifth of pregnant women received antenatal checkups from doctors and another 10 percent received them from other health professionals. Only 3 percent of pregnant women received checkups at home from health workers. The percentage that received antenatal checkups was more than double in urban areas (64 percent) compared to rural areas (29 percent). The median number of checkups in urban areas is 2.4 and in rural areas 1.6.

There are significant differentials between regions. More than two-thirds of pregnant women in the Hill region and only 15 percent in the Bundelkhand region received antenatal checkups. Women who did not receive antenatal checkups during their pregnancies in the three years preceding the survey were older women, women with higher order births, women from the Scheduled Castes and Tribes, illiterate women, and women with low income. Only 17 percent of women received their first antenatal checkup in the first trimester of pregnancy and another 14 percent in the second trimester. Checkups during the first trimester were much more in urban areas (40 percent) than in rural areas (12 percent). The median timing of first antenatal checkup is 3.7 months for Uttar Pradesh as a whole and more than one month earlier in urban areas (3 months) compared to rural areas (4.2 months).

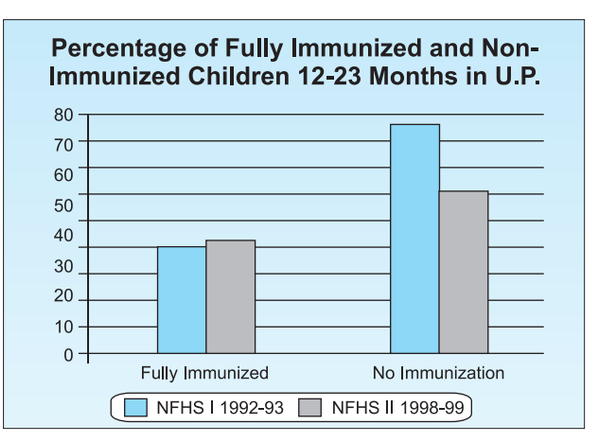


TT Vaccination. Neonatal tetanus is a significant cause of infant death in India. Two doses of TT injections given one month apart during early pregnancy prevents tetanus among new born infants and their mothers. Women who received two doses of the TT vaccine increased from 39 percent in 1992–1993 to 51 percent in 1998–1999. Nearly one-half of pregnant women did not get any or full protection from tetanus. In the Eastern region, 60 percent received two doses of TT injections, and in the Bundelkhand region, only 38 percent. Of the total number of pregnant women, 77 percent in urban areas and 47 percent in rural areas received TT injections.

IFA Supplementation. Because of the additional nutrient requirements of foetal growth, pregnancy often exacerbates nutritional deficiencies among pregnant women, causing anaemia. It is recommended that pregnant women consume 100 IFA tablets in order to prevent anaemia. Only 32 percent of pregnant women received IFA tablets in 1998–1999. There was only a marginal increase (2 percentage points) in the proportion of pregnant women who received IFA tablets between 1992–1993 and 1998–1999. As with TT coverage, IFA coverage is well below the state average in the Western and Bundelkhand regions (28 and 30 percent); for higher order births (20 percent); in rural areas (29 percent); among illiterate women (25 percent); and among women of low income (23 percent). Not all pregnant women who received IFA tablets received the recommended three-month supply. Among members who received IFA tablets during pregnancy, only two-thirds received the three-month supply and 74 percent consumed the IFA tablets supplied to them.

Place of Delivery and Assistance During Delivery. Another important thrust of the RCH programme is encouraging deliveries under proper hygienic conditions and with assistance from trained health professionals. In Uttar Pradesh, an overwhelming majority of births are non-institutional. There has been a marginal increase in the number of births that took place in institutions, from 12 percent in 1992–1993 to 16 percent in 1998–1999. Even in urban areas, only a little more than one-third of births took place in institutions. Nearly one-half of institutional deliveries were conducted in public health institutions; and seven of 10 deliveries conducted in public health institutions were attended by doctors, with the remaining by paramedical staff.

Postnatal Care. Postpartum checkups within two months after delivery are important, particularly for births that take place in non-institutional settings. Recognizing the importance of postpartum checkups, the programme recommended a total of three checkups, with the first and most crucial one within two days of delivery. Only 7 percent of non-institutional births were followed up by a checkup within two months of delivery. Of the



total followed up, 21 percent were within two days of delivery and 35 percent within a week.

Immunization of Children. Under the RCH programme, child health care includes the vaccination of children against six preventable diseases. During NFHS II, children age 12–23 months who received BCG, measles, and three doses of DPT and polio are considered fully vaccinated. Only one of five children in Uttar Pradesh was fully vaccinated in 1998–1999. The percentage of fully immunized children was relatively higher in urban areas (32 percent) compared to rural areas (19 percent). There was relatively higher coverage in the Hill region, with the lowest coverage in the Western (15 percent) and Bundelkhand (10 percent) regions. The proportion of male children fully vaccinated was slightly higher (24 percent) compared to female children (19 percent). There has been a significant decline in the proportion of children who have not received any vaccination from 43 percent in 1992–1993 to 30 percent in 1998–1999.

Other Child Health Care Measures. Only 14 percent of children ages 12–35 months in Uttar Pradesh received at least one dose of vitamin A. More than one-half of mothers (59 percent) were aware of ORS packets. However, only an insignificant proportion of mothers was aware of proper management of diarrhoea.

An urgent and immediate need exists to strengthen MCH care in Uttar Pradesh. Reasons for low coverage, particularly for the second and third doses of DPT and polio vaccinations, should be studied, and the programme should address them to improve coverage. There is also a need to improve ANM visits to households.

Discussant

Cristina Arismendy

There is a strong relationship between education, antenatal checkups, and institutional deliveries. In the national population policy, education is given a priority and also a close working relationship with local elected bodies, not only to promote infant mortality but to reduce the infant mortality rate. Health care delivery systems contribute to maternal health mainly through antenatal checkups. In all these aspects, the role and contribution of ANMs has to be recognized and should not be underestimated. They need to be trained and assisted for mobility. Mopeds were given to ANMs in different states but it was done with a difference in Tamil Nadu. ANMs in Tamil Nadu were given mopeds after training them on how to use mopeds. This helps ANMs to reach remote rural areas.

Discussant

M. C. Gupta

The National Institute of Health and Family Welfare (NIFHW) is a nodal agency for training as a component of the RCH programme for more than a year now. The RCH programme emphasizes training, particularly managerial and clinical skills. The second important aspect of the RCH programme is the community needs assessment approach, which was earlier called the target-free approach. This is a new concept that will take time for people to understand, conceptualize, and implement. When the NIFHW recently reviewed the various components of RCH and indicators to monitor performance of each component, it was found that there was a paucity of indicators regarding the health

education and IEC component. It is important to identify indicators to measure IEC activities.

In the late 1980s when reports about HIV and AIDS were published, many in the country thought it was hype and regarded it as the problem of the West. While the Western countries successfully contained the spread of HIV, the number is increasing at an alarming rate in India. We need to recognize that AIDS is a major problem and that IEC has a major role in changing the lifestyles and behaviour of people. For the management of STDs, it is necessary to follow a syndromic approach, which stood the test of time in many other countries. Clinic-based tests have to be encouraged when women and men go to hospitals for services, but that is not the point against syndromic approach. A series of sociological studies are required to understand the cultural and the social patterns in the spread of STD. The programme must be strengthened in order to improve immunization and antenatal care performance and to increase institutional deliveries or deliveries by trained personnel.

SESSION IV

MANAGEMENT OF HEALTH AND FAMILY WELFARE PROGRAMME IN UTTAR PRADESH

Chairperson: *A.P. Verma*

CNA Approach in Uttar Pradesh: Programme Performance
J.S. Deepak

Contraceptive Logistics Management in Uttar Pradesh
Gadde Narayana and J.S. Deepak

IEC for Demand Generation and Information Sharing
V.S. Chandrasekhar

Training Programmes for Skill Development: Policy Implications
Patricia M. Gass

Discussants: *Arun Kumar Sinha and V.K. Srivastava*

Session IV

Management of Health and Family Welfare Programme in Uttar Pradesh

The family welfare programme in Uttar Pradesh has become very complex: several new elements have been added to the programme over time and the number of service delivery outlets has increased to improve access to services. This complexity affects programme efficiency and effectiveness. This session deals with programme administration issues and identifies areas that need to be strengthened.

Remarks of the Chairperson

A. P. Verma

There has been a paradigm shift in the way family planning programmes have been implemented in the country. The paradigm shift occurred in the last 2–3 years, affecting not only the implementation strategy but also the overall approach of the programme. Everyone involved with the programme needs to understand these changes. All parts of the programme, including logistics, IEC, and training, have to function systematically and efficiently to achieve programme objectives. The four papers in this session deal with these and other issues.

Community Needs Assessment (CNA) Approach for Family Welfare: A Review of Experiences in Uttar Pradesh

J. S. Deepak

Since inception of the family welfare programme in 1952, the Government of India (GOI) has followed a target-based approach to family planning, wherein targets were assigned to the states and subsequently distributed to the districts and lower levels. Programme monitoring was based on achievement of method wise quantitative targets given to each state. Over a period of time, however, the contraceptive prevalence rate increased without a corresponding decline in fertility. Based on its experiences and the ICPD declaration, the GOI decided to implement a target-free approach (TFA) in two districts of Uttar Pradesh in 1995. In 1996, targets were abolished in the entire state. The main objectives of this paper are to describe the processes followed to implement the new system in Uttar Pradesh, to describe the opinions of personnel regarding the new system and implementation processes, and to analyze the effects of the new system on programme performance.

The state administration chose two districts, Agra and Sitapur, as the target-free districts in 1995. Agra was chosen because it was a relatively better performing district while Sitapur was a low performing district. SIFPSA sanctioned the operations research (OR) project in these two districts. The OR project introduced two broad interventions—adoption of the pregnancy-based approach and identification of unmet need to operationalize the target-free approach. The first activity undertaken was to introduce a modified eligible couple register (ECR). Subsequently, the following processes were followed to implement the two interventions:

- ANMs received a one-day intensive in-service training course with particular emphasis on identifying couples' reproductive intentions and how the ECR could be used for planning their work more efficiently.
- They also received a laminated sheet describing ways to use ECR information as a means of improving their knowledge about their respective service areas.
- A situational analysis of service delivery points was undertaken to identify needed upgrades. The centers were then equipped in accordance with the specified norms of the Government.
- Training needs were assessed and training conducted.
- Changes in the style of performance review meetings were introduced.
- Procedures for regular monitoring of ANMs' performance were worked out in detail.
- Supportive supervision and training was carried out.
- Local women served as volunteers to establish a link between eligible women and ANMs. Each volunteer was responsible for 50 households, and a scheduled day, place, and time were worked out to increase interactions between ANMs and the community workers.
- Case management services for reproductive tract infections were integrated into services provided by different PHCs.
- Two logbooks were introduced and ANMs were trained to manage services based on client needs.

In both Sitapur and Agra, programme performance dropped considerably in 1995–1996. Without taking the experiences of these two districts into consideration, the GOI decided to introduce the target-free approach in the entire state beginning in April 1996. Between April and September 1996, there was considerable confusion about the target-free approach. Different people interpreted the approach in different ways, adding to the confusion. Written guidelines were issued, but no efforts were made to train functionaries at various levels. The TFA manual supplied by the GOI was not even translated into Hindi. Many workers thought that no targets meant no work. Thus, in 1996–1997, the old system was abolished without replacing it with a new system.

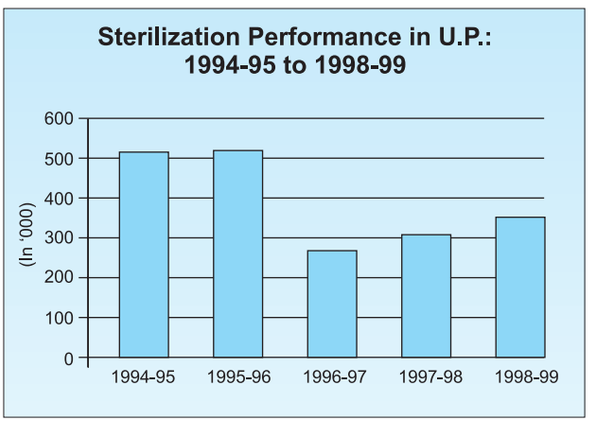
Given the lukewarm reception of the TFA, in December 1996, the state started preparatory work to strengthen the target-free system for 1997–1998. The Secretary of Family Welfare asked the Executive Director of SIFPSA for financial assistance to carry out TFA training in the state. SIFPSA asked AVSC International

to provide technical assistance for the training. AVSC developed a facilitator's guide keeping in mind the GOI's TFA manual. Facilitators for each district were identified and trained for two days at district headquarters. Facilitators in turn conducted training programmes for workers and medical staff for two days; opinion leaders also received one day of training to sensitize them to the new approach. While some districts followed the specified procedures to calculate expected levels of achievement, others did not. In a meeting of state secretaries in September 1997, the GOI modified the TFA manual and changed the nomenclature to the Community Needs Assessment (CNA) approach.

The CNA approach consisted of two components: (1) targets would be replaced by decentralized plans; and (2) a new monitoring system would replace the old target-based monitoring system. The new approach implied several specific changes:

- Expected levels of achievement were not specified from above but generated based on client needs at the worker level;
- Workers were expected to assess service needs and develop plans accordingly; and
- The programme would be monitored using indicators of access, quality, and client satisfaction.

Due to lack of resources and general apathy, the client-based surveys were not conducted in many subcentres. The Director General of Family Welfare in Uttar Pradesh felt that "only a small proportion of workers would be conducting surveys actually; the rest of the data appear to be generated at the PHC level. For five to six districts where the estimated



expected level of achievement was extremely low, the Directorate has made necessary changes. The system is not working at all."

The adoption of this policy reform in Uttar Pradesh affected several certain critical areas of programme performance as follows:

- Evidence from the field suggests that implementation of the CNA approach has not significantly involved the community. Programme personnel are also not proactive about the approach as they are afraid of a steep increase in community expectations, which the programme is not ready to meet.
- Removing targets was expected to improve the quality of services. The new monitoring system included a number of quality indicators. While there was not a significant improvement in the early acceptance of contraception or in continuation rates, knowledge of modern methods seems to have increased.
- Since the adoption of the new approach, programme focus has shifted to MCH services with particular emphasis on antenatal care, safe deliveries, and

immunization of children. New strategies have also been introduced, such as implementing a TT campaign for pregnant women, training dais, and increasing the number days available for immunization of children.

- The workers reported an improved self-image as a result of greater concentration on MCH services. One worker remarked, "The pressure of targets is no longer there and we are able to plan our work better. We cater to the problems of women and children and can visit villages more often. Our acceptability in the community has also increased."
- Family planning performance for all methods declined considerably in the first year following the adoption of TFA. Thereafter, sterilization performance improved but still has not reached the pre-TFA levels. The share of spacing and traditional methods has increased by 11 percentage points.

Operational Policy Issues Associated with Contraceptive Distribution in Uttar Pradesh

Gadde Narayana and J. S. Deepak

Contraceptive distribution in Uttar Pradesh is hampered by systemic problems requiring considerable attention. The purpose of this paper is to understand contraceptive distribution within the state and to identify issues that will lead to increased efficiency of the system. This paper examines the data on contraceptive distribution for three fiscal years: 1995–1996, 1996–1997, and 1997–1998 at the directorate, district, CHC/PHC, and subcentre levels.

Estimated Demand and Supply of Commodities. The State Directorate of Family Welfare calculates the total annual demand for modern spacing methods. These calculations are based on district-level requirements as reported to the chief medical officers of the districts. Normally, an additional 20 percent is added to the previous year's requirement to calculate the needs for the current year. The total estimated demand is then divided into four equal parts, each part representing quarterly demand. The annual request is sent to the MOHFW/GOI at the beginning of each fiscal year. The MOHFW, in turn, has its own system for determining the quantities of commodities that will be sent to the state. Rather than directly responding to the state's request, the MOHFW distributes supplies based on its own calculations,

Supply of Contraceptives from GOI to UP (Total in Million)

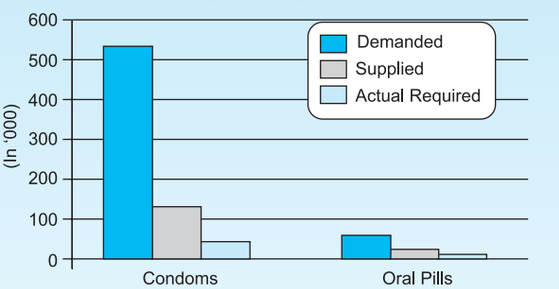
Quarters	Condoms		Oral Contraceptives		IVCDS	
	1996-97	1997-98	1996-97	1997-98	1996-97	1997-98
Q1	2.8	12.0	0	2.5	0.1	0.1
Q2	10.3	25.7	0.1	4.8	0.5	0.9
Q3	0	10.3	2.9	1.7	0.3	1.9
Q4	42.4	22.0	6.3	2.0	1.3	0.5
Total	55.4	70.0	9.3	10.9	2.2	3.4

available budget, and time needed for procurement.

Condoms. For 1996–1997, Uttar Pradesh estimated a need for 222 million condoms and received 55 million or approximately one-fourth of its request from the GOI. According to the PERFORM Survey, however, only 217,770 condom users are dependent on the public sector for their supplies. Using the standard assumption that each user uses 72 condoms per year on average, the total requirement for 1996–1997 would have been 16 million pieces. Thus, according to estimates of current use, the GOI supplied 39 million more condoms than needed in 1996–1997, a wastage of 71 percent of the number of condoms supplied by the GOI. Assuming similar levels of use, the estimated waste in 1995–1996 was 138 million condoms, and in 1997–1998, 54 million condoms.

Oral Pills. In 1996–1997, the Directorate of Family Welfare requested 23 million cycles of pills but received only 9 million, most of which were received in the last quarter of the year. As a result, in 1997–1998, the state reduced its request to 18 million cycles of pills but received 11 million cycles from the GOI, two million more than they received the previous year. According to the PERFORM Survey, however, the number of estimated pill users in Uttar Pradesh who received supplies from the public sector was 161,542. Assuming each user consumed 13 cycles per year, the total requirement for 1996–1997 would be two million cycles. The MOHFW supplied 7 million cycles more than needed according to the estimates of current use, a wastage of 78 percent of the total supplied for approximately three years.

Estimated Demand, Supply and Actual Requirement of Condoms and Oral Pills in U.P. (Million):1996-97



IUCDs. The difference in amounts requested and received was marginal for IUCDs. In 1996–1997, the state asked for 2 million IUCDs and the GOI supplied 2.2 million. In the following year, the state estimated the requirement at 3.2 million units and received 3.4 million from the MOHFW. In both years, the bulk of these supplies were received in the last two quarters. Based on reported IUCD use in the PERFORM survey, 189,634 IUCD users would have obtained services from the public sector in 1996–1997. If 35 percent are considered new users, 66,372 IUCDs would have been inserted. Thus, the total requirement for IUCDs in 1996–1997 based on PERFORM data would be about 70,000 IUCDs. The MOHFW supplied 2.2 million IUCDs to Uttar Pradesh in 1996–1997 resulting in wastage of more than two million units or 91 percent of the total number supplied.

Similar patterns of supply are observed for all contraceptive methods and at all levels in the system. Given below are some of the main observations based on inventory control and distribution at the PHC level and below:

- The supply of contraceptives to districts varied from year to year, which is more a

reflection of annual variations in the quantities supplied by the GOI to the state than in changes in contraceptive needs.

- All supplies are distributed to districts and lower levels irrespective of the needs of the districts. More supplies are distributed when more supplies are received, irrespective of whether needs have increased. By completely exhausting supplies, it appears that the main thrust is to show high performance at the end of the fiscal year.
- Neither the distribution of supplies from the district to PHCs nor from PHCs to subcentres is systemic. There are substantial monthly and annual variations in the distribution of commodities.
- There is little evidence at any level of the system of managing stock to compensate for months with no supplies.

Although the data show that contraceptive commodities are being distributed to lower levels in the system, what is less clear is what happens once they reach the service delivery points. Inaccurate contraceptive forecasting, based on amounts of contraceptives distributed in previous years rather than on data that take into consideration actual consumption, leads to purchase of excess commodities. Large capital investments are tied up in the pipeline. Excess amounts of commodities lead to inefficient utilization of available funds and huge amounts of wastage. Logistics and commodities make up a large part of program costs. Paying for commodities that are not needed is a waste of money that could be used to improve other aspects of the program. In addition, excess supply has implications for the cost of transport and storage at every step down the distribution chain. Furthermore, excessive quantities of contraceptives lead to wastage due to expiration of the product or deterioration in its quality.

Behaviour Change Communication for Health and Family Welfare in Uttar Pradesh: Opportunities and Challenges

V. S. Chandrasekhar

IEC or behaviour change communication (BCC) has always been an important component of the family welfare programme in the country and in Uttar Pradesh. The reach of communication channels has been increasing at a rapid pace. While it took more than 25 years for TVs to reach 195 million home viewers; in a span of seven years, the number of home viewers almost doubled to 362 million persons.

The reach of TV in India as per the estimates of NFHS in 1992 was 68 percent in urban areas and 19 percent in rural areas; for radio, it was 64 percent in urban areas and 36 percent in rural areas. The National Readership Survey in 1999 estimated television coverage to be 79 percent in urban areas and 41 percent in rural areas; for radio, the corresponding figures are 26 percent in urban areas and 29 percent in rural areas. The situation in Uttar Pradesh follows the same pattern. NFHS (1992) estimated that TV reaches 52 percent of the population in urban areas and 7 percent in rural areas. NFHS conducted in 1998 showed that 71 percent of households in urban areas and 36 percent in rural areas had access to TV.

This rapid change offers immense opportunities and also poses a great challenge for health communication. The opportunities

Percentage Households Owning TV and Radio and Uttar Pradesh

Source	India			Uttar Pradesh		
	Total	Urban	Rural	Total	Urban	Rural
Television						
NFHS (1992-93)	20.7	51.7	8.9	16.8	52.2	6.5
NRS 1999	38.0	73.8	23.7	48.0	71.0	36.0
Radio						
NFHS (1992-93)	39.3	59.4	31.6	32.6	53.1	26.6
NRS 1999	32.7	43.6	28.4	44.0	44.0	44.0

include the ability to reach a larger section of the audience in a shorter time, more frequently and more effectively. The challenge is our ability to respond effectively to these new opportunities.

Current Situation in Uttar Pradesh. On paper, the public sector has an impressive infrastructure for IEC. At the state level, an IEC Bureau has been established, which also houses a Media/Materials Resource Centre (MMRC). At the district level, the District Health Education and Information Officers (DHEIOs) and the Health Education Officers at the block level are supposed to play an important role in information dissemination. In practice, the IEC Bureau has not had a full-time director since its inception. The number of vacant positions at the district and block levels has hampered communication work.

As with most interventions, the number, skills, and motivation level of the human resource play a vital role. It would not be incorrect to say that Chief medical officers (CMOs)/Medical Officers in-charge (MOIC), have yet to appreciate the role and importance of IEC. They are more involved in actual service delivery and do not appreciate the fact that changing the behaviour of people is a long-term process.

The above situation has led to: (1) IEC being viewed as a product and not as a process;

Awareness of Modern Family Planning Methods in UP

	NFHS 1992-93			NFHS 1998-99		
Methods	Total	Urban	Rural	Total	Urban	Rural
Any Modern	95.0	97.8	94.3	98.3	99.7	97.9
Pill	64.3	87.3	58.5	84.7	97.1	81.7
IUCD	55.9	82.2	49.3	73.5	92.9	68.7
Condoms	66.8	86.9	61.7	83.1	96.6	79.7
Female Sterilisation	93.6	96.0	92.9	97.4	99.6	96.9
Male Sterilisation	88.0	93.4	86.7	92.5	97.7	91.2

(2) ad hoc interventions to suit the needs of the department rather than the client; (3) lack of consistency in messages being developed and disseminated at different levels; (4) lack of sustained activities; (5) inadequate emphasis on evaluating the impact of interventions; and (6) the non-involvement of the private sector.

For effective implementation of IEC, several issues need to be addressed:

- As a first step, there is a need for a comprehensive communication strategy.
- With the expected decentralization of IEC activities under the National RCH Communication Strategy, there is a need to strengthen the organizational capacity to handle multimedia campaigns at the state and district levels.
- Rather than general IEC training, training programmes need to be tailored to job requirements.
- Appropriate mechanisms and procedures need to be set in place to involve private sector professionals/organizations in various aspects of IEC.
- The MMRC established in Lucknow needs to be used to its full potential.
- Formal coordination mechanisms should be established between various departments and agencies involved in behavioural change.
- Judicious use of interpersonal communication and mass media should be encouraged.
- Demand-generation activities can contribute to programme goals only when high-quality services are available.

Uttar Pradesh has had mixed experience in implementing IEC interventions for health and family welfare. The challenge is to put a cohesive team and structure in place that can ensure effective communication interventions.

Training Programmes for Skill Development: Policy Implications

Patricia M. Gass

Since 1951, when India initiated its family planning programme, the main objective of the programme has been "to stabilize population at a level consistent with the needs of national development." The programme remained voluntary, and the Government has attempted to provide services and encourage those of reproductive age to use the services. The program has progressively evolved, albeit with some setbacks, into an ever more integrated family welfare programme, incorporating child survival and safe motherhood approaches. The RCH approach, which presently guides all aspects of services and training, operates under the premise that "people have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being, and couples are able to have sexual relations free of the fear of pregnancy and of contracting diseases."

The paradigm shift embodied in the RCH approach will become a reality only when human resources are developed through training. This paper explores the following questions with a view to offering recommendations that might be considered when formulating a population policy.

What is training? What is a training programme for skill development? When should we do it? How should we do it? How we do it at present? What are some of the problems we have had with what we have done? What are some of the lessons we have learned thus far? What recommendations can we make to policymakers? Some definitions of key terms follow:

Training can be defined as "instructional experiences designed to develop, update, or reinforce knowledge and skills and to build a base of positive attitudes." Skills training is designed to teach a set of skills that enable trainees to perform specific new tasks. Trainees do not possess skills before the training. There are three main steps to follow to train someone to become competent in a skill: (1) skills introduction; (2) skills demonstration; and (3) skills practice.

Training Programmes for Skill Development. In-service training has been undertaken by the GOI under the Family Welfare Programme, particularly under the MCH Programme, the CSSM Programme, the Target-Free Approach, and the RCH Programme. In Uttar Pradesh alone, there are almost 60,000 sanctioned positions for health personnel, of which 54,200 positions are filled. Of these positions, 12,000 are doctors. Uttar Pradesh spends about 2.67 percent of its total budget on health. Nearly 67 percent of the health budget is spent on salaries, 19 percent on infrastructure, 7 percent on services, and less than one percent on training. There is an urgent need to review the allocation of resources for training.

India has done a tremendous amount of work in planning holistic comprehensive training. Self-critique by the Government and constructive critique by eminent scholars show that there are gaps between training that was planned on the basis of human resource development needs and training that was imparted. Some of the lessons learned in the process are important for fine-tuning training policies.

Skills to be Learned and New Skills to be Re-learned by Health Personnel to Implement RCH Programme

New skills to be learned	Skills to be re-learned
Management of RTIs and STIs	Management of normal delivery
Management of gynaecological problems	Emergency obstetric care
Adolescent health, sexuality and gender education	Menstrual regulation, medical termination of pregnancy
Interpersonal communication and counseling	Sterilization, IUCD insertions, oral contraceptives
Neonatal care and care of low birth weight babies	Management of acute respiratory infections and diarrhoea
Use of partograph in management of labour	Information, education and communication that will lead to behaviour change

- Training must be relevant and relate directly to the job responsibilities of the participants.
- Training should be based on principles of adult education, which are based on the assumption that people participate in courses because they are interested in the topic, know what they want to gain from the course, and are actively interested in gaining new knowledge and skills.
- Competency based training focuses on learning by doing, which is the best way to learn new skills once the theory has been understood.
- Behaviour modification, or modeling of appropriate skills by the trainers, facilitates learning.
- Training to well-defined performance standards for each skill or activity enhances acquisition of new skills and self-confidence.
- Trainees should be assessed according to how well they perform a skill rather than how much they have learned.
- Coaching and follow up at the worksite to ensure that training is being utilized facilitate sustainability.
- Counseling skills training of trainers where representatives from all classes of health workers are selected to be trained to train ANMs in counseling skills has resulted in behaviour change.

Policy Implications

- Conduct an external assessment of RCH training in Uttar Pradesh to assess strengths and weaknesses with a view to fine-tuning existing practices.
- Liaise with NGOs and other agencies conducting successful training on RCH to share training materials, lessons learned, and best practices.
- Conduct on-site whole site training when feasible. A good example of whole-site training is the infection prevention training that the IFPS Project provides to all CHCs and PHCs.
- Increase the budget allotted to training so that it is commensurate with the task
- Orient CMOs, chief medical superintendents, and deputy CMOs on the appropriate selection of trainees, the purpose and content of training, competency-based training, performance improvement, and supportive supervision approaches.
- Provide refresher courses for lead trainers emphasizing adult learning principles, interactive participatory training approach, competency-based training using learning guides for trainers and trainees, and a performance improvement approach.
- Consider raising the profile of training by designing and releasing outstanding trainers for full-time training, rather than adding training as an additional responsibility.
- Ensure that equipment and supplies are available at the worksite so that trainees can make use of their new skills.
- Increase the use of appropriate IEC to publicize services available.
- Provide training in supportive supervision to supervisors.
- Strengthen follow-up and supportive supervision at the worksite after training.
- Train worksite personnel in problem-solving techniques to address issues not related to training that stand in the way of provision of quality services.
- Give recognition to providers and sites where quality services are provided.

Discussant

Arun Kumar Sinha

The CNA approach was, in the first phase, rushed through and then the actual implementation started. We need to take into consideration the shortcomings of the pilot phase and work out strategies for its effective implementation. Implementation of any new system takes time. The paper on logistics management dealt with the contraceptive distribution system in Uttar Pradesh. Stock-out situations affect programme performance. The stock-out situation is mainly due to wastage. A simple stock register maintained at the subcentre level is not enough to overcome this problem. We need to think about the steps needed to improve the distribution of contraceptives at all levels.

The paper on IEC pointed out strengths and weaknesses of the programme and the current position. It has also drawn our attention to male involvement, which is an essential component of the family planning programme. We need to have a communication strategy and an action plan to implement the strategy and this recommendation should find a place in the policy document. We should keep in mind recent developments in communication technology but should not forget about the traditional media. An effective communication strategy should give due recognition and importance to both modern and traditional media.

The last paper was about training programmes for skill development. The paper points out that the resources allocated for training in the health and family welfare budget were less than 1 percent. Recognizing the importance of training, a new training policy has recently been developed, which states that 1 percent of the total budget of all departments should be allocated to training.

Discussant

V. K. Srivastava

In Uttar Pradesh, we have already undertaken various training activities. Almost 15 years ago, a systematic effort was made to impart training with the introduction of the universal immunization programme. Training systems were further strengthened under the CSSM programme, and systematic training was imparted throughout the state. But this training was largely knowledge-based. Under RCH programme, there was an organized effort to impart skills-based training. One of the problems faced in skills-based training, however, was the lack of clients to practice on at the time of training. To overcome this problem, the duration of the training has to be increased or alternate centers have to be identified.

In Uttar Pradesh, a training policy document has been prepared and one exists for health sector. A provision of minimum of 2 percent of budget allocation was made for the training. As far as induction training of medical officers is concerned, under India Population Project (IPP) VI in Uttar Pradesh, all recent graduates who joined the health service underwent two months of training. Now the duration has been reduced to one month. There is only one training institution at state level, and we are not in a position to cope with the workload. There is now a 3-year waiting list for induction training. Impact assessment of induction training is one area that requires attention.

IEC is very important. The IEC Bureau and the MMRC have already been set up with help from SIFPSA. Now they have to be activated. Most of the positions in the IEC wing in the health education section are vacant. As far as contraceptive supplies are concerned, a tremendous job has been done in analyzing the situation. The answer lies in streamlining the system from the center to the subcentre level. ANMs were trained in the CNA approach, but they are not preparing subcentre plans. This needs to be examined.

SESSION V

DECENTRALIZATION OF PROGRAMME IMPLEMENTATION

Chairperson: *Nina Puri*

Need for Decentralization: An Analysis of Organizational Structure
J.S. Deepak

Decentralization District Action Plans: Issues and Challenges
Aradhana Johri

Role of Panchayats in Decentralized Health Administration
A.P. Verma

Unmet Need for Family Planning and VIKALP Experiment: Implications for Uttar Pradesh
Devendra Kothari

Discussant: *Rameshwar Sharma*

Session V

Decentralization of Programme Implementation

Uttar Pradesh has taken a series of steps in recent times to decentralize the health and family welfare programme. There are also innovative projects on decentralization of the programmes. The highly centralized health department is still a major constraint for effective implementation of the health and family welfare programme. The four papers in this session discuss issues related to decentralization and ways to strengthen the process.

Remarks of the Chairperson

Nina Puri

In this session, we are going to discuss the role of panchayati raj institutions in decentralized planning and administration, an area in which Uttar Pradesh has taken a lead role in recent times. An organizational analysis of the health and family welfare department will uncover strengths and weaknesses and the remedial measures needed. Following this, we have papers on the functioning of decentralized action plans and the experiences of other states in decentralized programme implementation.

Need for Decentralization: An Analysis of Organizational Structure

J. S. Deepak

The structure defines the network of reporting relationships in an organization. The greater the number of hierarchical layers in an organization, the greater the complexity in reporting relationships. This complexity of reporting relationships at times is compounded by the centralized control systems. The health and family welfare organization in Uttar Pradesh, a simple and less differentiated organization to begin with, has grown in complexity with the addition of more programmes and more elements to existing programmes. There are six clearly defined levels in the organization: the Secretariat, Directorate, Division, District, Block, and Subcentre. At each level, health personnel with different ranks, job functions, and responsibilities perform tasks that contribute to the achievement of programme objectives.

Secretariat. The Secretariat is headed by two ministers, one for health and one for family welfare, both have an independent charge. The

administrative head of the department is the Principal Secretary, who provides overall guidance to the department in terms of both policies and programmes. The Principal Secretary is assisted by two secretaries, one for health and one for family welfare. There are 10 different sections in the Secretariat; each headed by either an undersecretary or deputy secretary. Each of the sections has written job functions, but these functions have not been reviewed for a long time.

Directorate. The Director General of Family Welfare is in charge of overall programme implementation. Below the Director General in the Family Welfare Directorate is the Director (Family Welfare), to whom the three additional directors below are supposed to report on all aspects of the family welfare programme. More often than not, however, the additional directors report directly to the Director General (Family Welfare), making the position of Director (Family Welfare) redundant. All administrative and financial powers are with the Director General (DG) (Family Welfare) and all staff functionaries, such as finance controller, administrative officers, and accountants, report to the DG. The Directorate has four main sections: IEC, family welfare, MCH, and universal immunization. All officers of the directorate are supposed to tour the districts to review programme implementation and performance. Since the additional directors of the Family Welfare Directorate are equivalent in rank to the additional directors of divisions, the directorate staff does not supervise the work of divisions. Even if each directorate officer spends 120 days on tours, which is rare, each district can be visited only once in a year. Supervision of work performed at the district level is negligible and largely confined to meetings with CMOs in Lucknow.

Division: The Additional Director (AD) position at the division level has been created with the aim of decentralizing programme management. The main functions of the AD Office at the division level are: (1) monitoring and supervision of various health and family welfare programmes in all districts of the division; (2) provision of logistics support to districts; (3) communication of instructions and guidelines to districts; (4) coordination of functions of the CMO and the Chief Medical Superintendent in each district; and (5) coordination with other departments in the division. Additional Directors at the division level feel that they are not part of the decision-making processes of the system and are largely used to perform a "post office function" for the Directorate. They are supposed to tour about 10 days per month, but the POL (petrol, oil, and lubricant) budget provided for the purpose is inadequate, and consequently they often rely on CMOs for POL.

District: Each district has two officers of equal rank: a Chief Medical Superintendent (CMS) and a CMO of Health and Family Welfare. The CMS is in charge of all hospitals in the district with more than 100 beds, and the role is largely confined to curative services. The CMO looks after all sub-division hospitals, CHCs, upgraded PHCs, and block PHCs. On the technical side, two deputy CMOs, one for family welfare and the other for MCH services, provide technical assistance. In addition to these two deputy CMOs, each district has deputy CMOs to supervise programme implementation in each sub-division. All of them are located at the district headquarters

and not at the sub-division level. Deputy CMOs, superintendents of CHCs, and medical officers of sub-division hospitals are of the same rank. In a hierarchical system, this is major constraint for supervision of work in sub-divisions, as medical officers do not pay attention to the instructions given by the deputy CMOs, making their role as supervisors ineffective. Since deputy CMOs of sub-divisions are located at district headquarters, they have to travel long distances to supervise institutions in their sub-divisions.

Block Level and Below: At the block level, there are different types of institutions: CHCs, upgraded PHCs, and block PHCs. These institutions have similar functions but different nomenclature according to the facilities available in each, such as the number of in-patient beds. Below CHCs and PHCs are additional PHCs. Additional PHC Medical Officers (MOs) do not have drawing and disbursement (DD) powers because the financial rules stipulate that medical officers that have DD powers should have a minimum number of years of experience. Since most of the Additional PHC MOs do not have the stipulated number of years of experience, they have no DD powers, and consequently, their effectiveness in this role is very limited.

The health and family welfare organization faces several challenges. Based on interviews conducted at various levels, the following the recommendations are offered:

- Job functions of all officers should be reviewed and written to avoid overlaps, to distribute work evenly, and to maintain a manageable span of control and unity of command.
- Authority, to the extent feasible, should be decentralized at the same time that accountability should be clearly spelled out. A large and complex organization like health and family welfare cannot produce desired results with centralized systems.
- Medical officers of Additional PHCs should be given DD authority, after appropriate training, waiving the experience clause.
- Deputy CMOs who are area officers should be posted at the sub-division level and made responsible for performance of all health institutions in the sub-division.
- A pool of medical officers should be created at both the district and division levels to provide services at RCH and sterilization camps. This to a large extent would reduce the dependence on the CMS and solve problems of coordination and service delivery.
- The Additional Director's Office should be strengthened by adding more staff. The Additional Directors should be made responsible for achievement of expected levels of performance in the division.
- At the Directorate level, there should be three Director Generals for health, national health programmes, and family welfare. The ACRs of divisional officers should be written by all DGs.
- At the secretariat level, all family welfare functions should be with one secretary and all health functions with another secretary.

Decentralized District Action Plans: Issues and Challenges

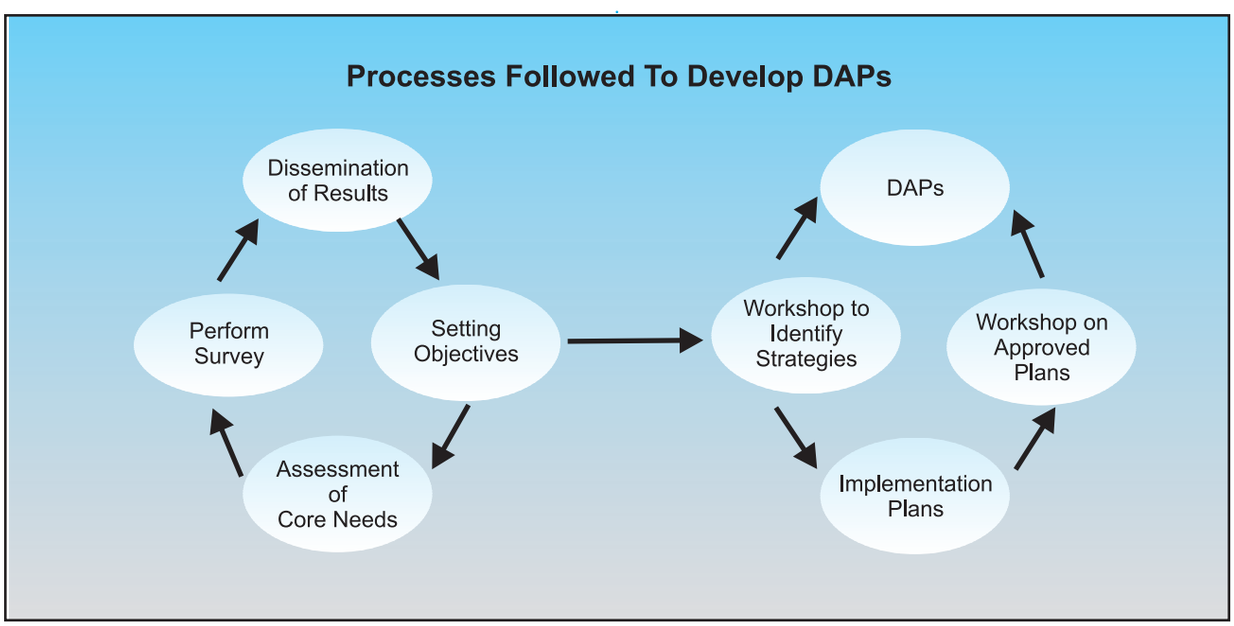
Aradhana Johri

The booklet called "Making Things Happen" documents SIFPSA's efforts in decentralized planning and implementation for RCH. The

need for decentralized planning is very obvious. If we look at data related to family planning and MCH indicators, we notice tremendous variations among regions within the state. Innovative programmes based on local needs are absolutely essential to achieve results. The centralized programmes offer no scope for innovation. The health and family welfare organization suffers from centralization, rigid procedures, and constraints in the flow of resources. The ideas conceived somewhere by some bright persons are quickly translated into instructions and circulars. This happens all over India and Uttar Pradesh is no exception.

Many in the field know what needs to be done but do not have a means to participate in the design and implementation of new programmes. SIFPSA used district-specific data from the PERFORM Survey and disseminated the results to districts. Health personnel at various levels and other stakeholders were involved in setting their own objectives for the district. A series of workshops at various levels were conducted to develop strategies. Since the district action plans were based on an integrated approach, a thorough review of all NGOs in the district was carried out to identify NGOs eligible for grants. A similar exercise was carried out with other sectors, such as cooperatives and Indigenous System of Medicine (ISM) practitioners.

One of the strategies that evolved from this exercise was the need to create a conducive environment. Most of the discussion in the earlier sessions revolved around this theme. Religious and opinion leaders were considered important for creating a conducive environment. Recently, village development committees for health have been formed, which came into existence after formulation of the district action plans. However, there is a potential to involve these committees in implementation of the district action plans (DAPs).



The other important strategy was demand generation. DAPs concentrated on specifying local needs using the available media ranging from cable TV in Varanasi to folk media in other districts. Improving the quality of service was found to be important. In the DAPs, this consisted of upgrading facilities and training personnel at various levels to improve technical and communication skills. Improving access to services was another important element. We may generate demand, but it is equally important to meet this demand. To improve access, the integrated RCH services camps were held, which was a subject of discussion in the earlier session. There is a shortage of lady medical professionals in the Government sector. This situation is further compounded by the fact that many in position would like to work in district hospitals rather than in remote rural areas. The DAPs hired lady medical professionals from the private sector to serve in remote areas. In institutions served by lady medical professionals, the number of cases has increased considerably. In Uttar Pradesh, a private medical professional serving in public health institutions was unthinkable a few years back. It is reality now. In addition to demand and access, DAPs also concentrated on improvement of logistics. There are several constraints in this regard, but then market forces have been activated. The community-based distribution (CBD) workers in NGO and cooperative sector projects have been involved in contraceptive sales, and a major social marketing project was launched with the help of Hindustan Latex Limited for marketing of contraceptives in small towns and villages.

The district society called DIFPSA was constituted with the District Magistrate as chairperson and prominent members of the district from public and private sectors as members. District Magistrates cannot devote their time fully to one sector or one set of activities. They are part of every activity in the district. To assist DIFPSA, a project management committee was established. Should this unit be part of the department or outside the department? This was the question raised and debated at considerable length. Finally, the decision was made to strengthen the district administration by creating a management unit outside the health department but working for and accountable to DIFPSA. The Project Management Units (PMU) in each district have prepared operational plans with a set of activities to be completed in a specified time frame. This formed the basis for all monitoring and evaluation. PMU staff and officers visiting the district from SIFPSA headquarters kept a constant watch on local requirements. A key to the success of the DAPs is the flexibility available in their implementation. For instance, during the course of DAP implementation, it was found that slum areas in Meerut city were not having any health facility. A decision was made to train all dais in that area even though that activity was not part of the district action plan.

Achievements. In all DAP districts, several meetings were conducted with religious leaders. In these districts, religious leaders showed an interest in programme implementation and actively participated in the service camps conducted in their areas. In DAP districts, nearly two-thirds of elected representatives of rural and urban bodies have

been trained. As per the constitutional amendment, one-third of the members elected to these local bodies are women. In the beginning, female pradhans never attended but sent their husbands, who are popularly known as pradhan patis. The few female pradhans who attended the programme always preferred to sit on the floor instead of on the chairs provided. Given this experience, a decision was made to conduct separate training for female pradhans. Pradhans who attended the training programmes started getting people to the RCH camps. Folk media is extremely important for generating demand. Nearly 1,000 folk media programmes have been conducted in DAP districts. Involvement of other sectors such as ISM practitioners, cooperatives, and the organized sector also proved to be extremely useful.

Several benchmark indicators were identified to assess the performance of DAP districts. A performance-based disbursement system has been negotiated and implemented. Sterilization performance in DAP districts is 12.9 percent higher than the average state increase. One of the most important and significant achievements of DAPs is the improved ability of districts to respond to requirements without delay and, in most cases, within a day. These successful experiences have to be scaled up to other districts.

Role of Panchayats in Decentralized Health Administration

A. P. Verma

This paper has two parts: the first part deals with the status of the panchayat raj institutions in the state and the second part concentrates on linkages between panchayati raj institutions and health programmes. The panchayat system in rural areas and elected urban bodies, based on 73rd and 74th Constitution Amendments, have several levels such as village panchayat, kshetra panchayat, and zilla panchayat. This paper largely deals with village panchayats because that is where decentralized health system has greatest relevance. The village-level panchayats in India have existed for a long time and these democratic institutions are based on the philosophy "of the people, for the people, and by the people". Gandhiji once said, "Indian independence must begin at the bottom. Every village will be a free republic with a panchayat having full powers."

Article 40 of the Constitution of India, the Directive Principle of the State Policy, provides for the establishment of panchayats at the village level. The Directive Principle of the State Policy is an expression of the intention and is not meant to be nor is it a mandatory provision of the Constitution. In 1992, however, a sea change occurred with the amendments to the Constitution of India that established elected local bodies in rural and urban areas of the country. The provision of the 73rd Amendment was both mandatory and discretionary in nature. The mandatory provisions are that there would be a three-tier system of panchayats at the village, block, and district levels in rural areas. The panchayats would have five-year term, and each state would constitute an Election Commission to hold elections to local bodies and a State Finance Commission for the devolution of funds to panchayats. Another important mandatory provision is the reservation of seats in panchayats for women, Scheduled Castes, and

Position of reservation (Category-wise) of Chair Person and Members of Three-tier Panchayat's (as after 1995)

Sl. No.	Name of Institution	Designation	'Number'								
			Total	ST		SC		Backward		Unreserved	
				Male	Female	Male	Female	Male	Female	Male	Female
1	2	3	4	5	6	7	8	9	10	11	12
1	Gram Panchayat	Pradhan	58620	785	387	8248	4062	10604	5223	19638	9673
		Member	678148	8056	4527	96081	47540	12247	61123	227515	112059
2	Kshetra Panchayat	Pramukh	901	12	6	126	63	162	81	303	148
		Member	57288	764	381	8020	4010	10313	5156	19192	9452
3	Zila Panchayat	Chairman	68	1	x	10	4	13	6	23	11
		Member	2529	33	17	354	177	456	227	844	421
		Total	797564	9661	5318	111839	56866	143795	71816	267515	131764

Total No. Male: 532800

Total No. Female: 264754

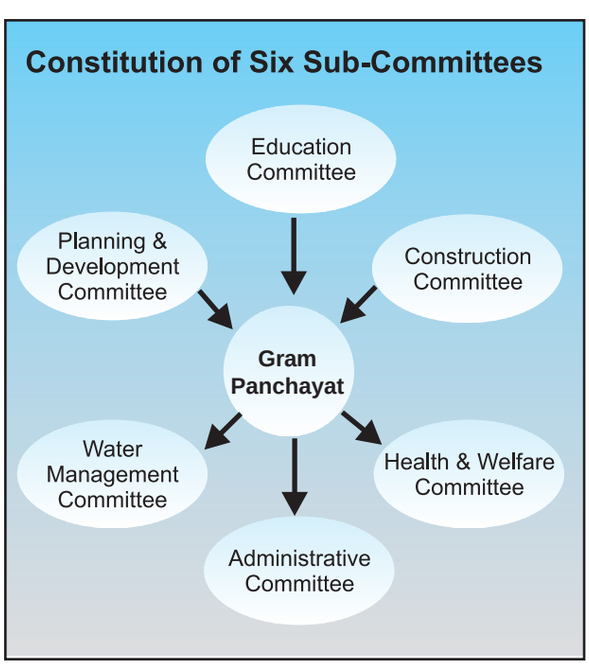
Scheduled Tribes. In fact, one-third of all seats have been reserved for women. The amendment has two discretionary provisions. The Eleventh Schedule of the Constitution enumerates a number of functions that could be passed on to the panchayats for implementation. This simply means the state can decide to pass on all or some of the listed functions. The other discretionary provision is that the state legislature can decide to reserve posts for Other Backward Classes (OBCs).

In Uttar Pradesh, the 73rd Amendment has been implemented in two stages. The first began when the state amended the Panchayati Raj Act of 1947, which related to the village panchayat, kshetra panchayat, and zilla panchayat and the 1961 Act relating to the block and district panchayats. The idea was to bring these two major acts in line with the 73rd Amendment.

The new Act passed in Uttar Pradesh provided a five-year fixed term to the panchayats. Elections have to be held before completion of the five-year term of elected bodies. No panchayat can be suspended or superseded; however, they can be dissolved for reasons given in the Act. The seats reserved for Scheduled Castes and Scheduled Tribes would be allocated in proportion to their population. Seats reserved for OBCs should not exceed 27 percent of total seats. Within each category, one-third of positions for both members and chairpersons have been reserved for women. The Election Commission was constituted in 1994 and the elections to panchayats were held in April 1995 in plain areas and in January 1996 in hill regions. The next elections for the village, kshetra, and zilla panchayats are scheduled for April 2000 and January 2001.

The second stage of decentralization started in 1999, and the fiscal year 1999–2000 was declared as the year of decentralization. During this period, the state Government decided to devolve administrative and financial powers to local bodies and state Government transferred the assets and functions of 12 departments to elected bodies. Some of the

important departments were education, rural development, women and child welfare, state tube wells, animal husbandry, youth welfare, drinking water, medical and health, public distribution system, scholarships, and pensions. The next important step taken was to transfer staff of eight of the 12 departments to panchayats. These staff have been designated as village panchayat development officers. They are multi-purpose functionaries to implement various programmes at village level. At present, there are about 61,054 village panchayat officers serving panchayats in Uttar Pradesh. An attempt has been made to have at least one officer for each village with 1,000 population. All village panchayat officers received rigorous training and at least three training programmes were held from April to October 1999. The State Finance Commission constituted in 1994 recommended that 11 percent of total state revenue should be devolved to local bodies. Based on this recommendation, a decision was made to devolve 7 percent to urban bodies and 4 percent to rural bodies. Thus, Rs 5,830 million were devolved to panchayats in 1999. The panchayats have freedom to levy taxes and introduce user fees to generate additional resources.



In Uttar Pradesh, 797,554 persons were elected to local bodies; of these, 532,800 were male members and 264,754 were female members. The panchayats work through six sub-committees that deal with education, construction, health and welfare, administrative matters, water management, planning and development, etc. Each committee formulates plans and monitors and reviews implementation.

The rural health system has suffered as a result of the poor service delivery system, inadequate coverage, unmotivated staff, poor quality of supervision and monitoring at the field level, and lack of accountability. Inadequate infrastructure and poorly trained staff are other problems that decentralized systems can overcome.

Panchayati raj institutions are not totally political bodies. As constituted, they serve as both political and administrative bodies, and therefore, are in a position to formulate and implement policies and programmes. Involvement of panchayati raj institutions will help to implement a bottom-up approach based on client needs rather than a top-down approach. It is also possible to achieve synergy by achieving a convergence of services at the local level. Panchayats also ensure direct involvement of stakeholders and integrate their interests in programme plans and also

involve them in programme implementation. There are two distortions that enter into development programmes: gender bias and urban bias. Both could largely be overcome in a decentralized system.

Many functions and responsibilities have been passed on to panchayats, and it is now the responsibility of the health department to see that the transfer of these functions is completed quickly and effectively. There is a need to provide continuous training and sensitization programmes to panchayat members and panchayat development officers. They also need to have effective IEC and technical support. If the requisite support and training are extended to panchayati raj institutions, the implementation of decentralized programmes will be very effective.

Unmet Need for Family Planning and Vikalp Experiment: Implications for Uttar Pradesh

Devendra Kothari

Estimates of unmet need for contraception, derived from fertility and family planning surveys have now become a base for determining the potential demand for family planning services. Based on the NFHS, about 20 percent or 33 million of currently married women of reproductive age in India in 1999 have an unmet need for family planning. If all such women were to use family planning, the contraceptive prevalence rate would increase from 45 to 60 percent, the level needed to achieve replacement level fertility. However, the estimated aggregate level of unmet need determined by a sample survey is not sufficient for a managing family planning programme based on client needs since it does not tell the provider who the clients are and where they are located. Unfortunately, few large-scale attempts have been made to use the concept of unmet need as a tool for micro-planning. Under the VIKALP experiment in Rajasthan, an attempt has been made to operationalize the concept. The aim of this paper is to share the findings of the experiment and highlight lessons learned in the process and their relevance to Uttar Pradesh.

VIKALP Experiment. VIKALP (meaning an alternative) provides a comprehensive framework for managing the family planning programme. This two-year experiment was formally launched in 1995. In the VIKALP districts, service delivery was redesigned in such a way to make client-oriented and high-quality services available to all those with a need for family planning services. A micro-planning procedure, based on client segmentation, was followed to identify those with a need for family planning and reproductive health services. Grassroots-level workers at the subcentre level gathered the basic information needed for micro-planning procedure using the modified Eligible Couple Register (ECR). This exercise was carried out at the beginning of each fiscal year to determine the need for family planning services. The data collected were analyzed and the resultant client segmentation process enabled the ANM to have a clear picture of the service population and the inputs needed, allowing for a bottom-up approach to service delivery. Workers were provided with a Service Delivery Booklet containing the names and addresses, along with other background information, of couples needing a particular

Unmet Need for Family Planning Services its Conversion in Vikalp Districts, 1995-96

	Vikalp Districts		
	Tonk	**Dausa**	**Total**
Total eligible couples	167,985	171,884	339,869
Couples having unmet need for FP services as of April 1, 1995	28,827 (17.7)	27,451 (16.0)	52,278 (16.8)
Couples with unmet need contracted by the workers 1995-96	21,773 (73.0)	18,128 (66.1)	39,901 (69.7)
Couples with unmet need who accepted a method of contraception during 1995-96 and were continuing use as of March 31, 1996	16,134 (54.1)	12,948 (47.2)	29,082 (50.8)

service such as antenatal care, postnatal care, or family planning. The ANMs were required to contact these couples and provide them with the necessary information and services. A system of improved supportive supervision was introduced to ensure at least two contacts per year with identified couples, with proper follow-up to improve the retention rate for spacing methods. An internal monitoring system was introduced to check the reliability of the information provided by workers at various levels.

Merely identifying client needs will not help unless it is backed by a client-centered service delivery system with due emphasis on accessibility, availability, and quality. Over time, a number of institutions at the sub-district level have been created in India to provide family welfare services, but they have not been effective since they are scattered and are not properly equipped to deliver the required services. This realization led to the establishment of Reproductive Health Centres at the block level, which served as the nodal point for all reproductive health services in that area and thus acted as the first referral unit. Other strategies put in place included: women satellite camps to reach difficult areas and depot holders to improve the accessibility and availability of spacing methods. To implement the above, the tasks and job responsibilities of workers were defined with clarity, and certain modifications were made in the line command within the organizational structure. The District Family Welfare Bureau (DFWB) headed by a District Manager with a background in management, was declared the nodal agency to manage the programme in the district. The district manager was supported by three deputy managers looking after the systems and subsystems such as operations (logistics and referral), motivation (communication and training), and monitoring (MIS and evaluation). As a result of these changes, around half the unmet need couples accepted some modern method during the first year of the experiment. ANMs could contact 70 percent of couples with

unmet need. The conversion rate might have been even higher had the ANMs been able to contact all the unmet need couples.

Implications for Uttar Pradesh. To attain replacement level fertility by 2021 or earlier, the first step is to ensure that 60 to 65 percent of eligible couples adopt contraception by 2016 with an appropriate method mix. Although this appears to be a difficult task based on recent trends, it is possible to achieve this goal by focusing on unmet need for family planning services. Recent data show that 30 percent of currently married women of reproductive age had an unmet need for family planning services. It may be noted that the concept of unmet need is dynamic in nature since it changes with the changing socio-economic and other conditions prevailing in the society at any given point of time. Thus, the whole management approach must be focused on meeting unmet need for family planning services and avoiding unwanted pregnancies. In order to operationalize unmet need in Uttar Pradesh, a system-based approach must be put in place, including such components as an essential services package, micro-planning and client segmentation, supportive supervision and monitoring, strengthening of the service delivery system, introduction of system-based management, revamping of the organizational structure, and investments in research and development. Systematic changes to service delivery systems do not necessarily require additional resources, but they do require political and administrative will.

Discussant

Rameshwar Sharma

Decentralization of programme implementation really depends on what the provider and the system want to do for decentralization. Another central issue is community involvement. We talk about unmet need for family planning, but we do not talk about the unmet need for ANC and PNC services, immunization, and safe motherhood services. We need to empower the community to participate in programme planning and implementation, even though the community is not yet prepared for this level of involvement. Another challenge we need to address is how to build capacity at the community level. It is not a question of training community members but involving them. We conducted a study in Rajasthan and recommended that the entire health department, other than the district hospital, should be under the zilla parishad. We also recommended that panchayats should be given powers to identify health volunteers. Similarly, we proposed that zilla parishads should recruit medical officers up to the level of the zilla parishad. There is also a need to clearly separate the public health stream from the hospital administration stream. Reorganization along these lines will improve the system tremendously.

The structure should encourage community participation in health programmes. Enhancing accountability at various levels leads to teamwork. The top level of administration should concentrate on policy and strategic thinking.

SESSION VI

LINKAGES WITH OTHER DEPARTMENTS

Chairperson: *S.P. Gaur*

Multi-sectoral Approach to Health and Family Welfare in Uttar Pradesh
K. Chandramouli

ICDS Programme in Uttar Pradesh
Krishna Gopal

Rural Development Programme in Uttar Pradesh
Nasim Zaidi

Discussants: *Saurabh Chandra, Bachchi Lal, and A.K. Das*

Session VI

Linkages With Other Departments

Family welfare programme performance is influenced by the performance of several related departments, such as education, rural development and women and child development. Intersectoral coordination at the grassroots level between various departments is essential to conserve scarce resources and achieve synergy. A review of experiences of other departments is the main theme of this session.

Remarks of Chairperson

S. P. Gaur

There are three interesting and inter-related papers representing three development sectors. The first paper deals with multi-sectoral approach to health problems; the second paper examines various rural development programmes; and the third is on integrated child development scheme. Experiences of other departments are very useful to population stabilization programmes; also, the performance of one development sector influences the other.

Multi-Sectoral Approach to Health and Family Welfare in Uttar Pradesh

K. Chandramouli

This presentation deals with an effort to develop a strategy for a multi-sectoral approach to the implementation of various health and family welfare programmes, both at policy-making and implementation levels. There has been a considerable increase in plan allocations to both family welfare and health sectors over time. Most of the health and family welfare programmes operate as vertical, single objective, technologically sophisticated programmes, which, however, do not have horizontal linkages in the field. Nevertheless, there are other related programmes such as rural sanitation and drinking water. The drinking water programme in Uttar Pradesh has an allocation of Rs 350 crores. There is no linkage between drinking water and rural health. Programmes such as Integrated Child Development Services (ICDS), women development and poverty alleviation have focused on health bias but operate in isolation. Convergence of these programmes has never really been attempted.

Uttar Pradesh has 150 million people and South India 196 million. Life expectancy is low and infant and child mortality rates are high in Uttar Pradesh compared to South India. In addition, the maternal mortality rate is unacceptably high. In this situation, it is necessary to develop an action plan at the district level and below in order that available funds for the social sector are most optimally used and that duplication and waste is avoided. Basically, the health sector does not have any district plan, with decisions responding to emergency situations. There is no importance given to systematic planning and programme implementation, as well as no periodic surveillance in health and family welfare sectors in the district. One way of improving the present situation is to prepare a health plan for the district involving all development departments. The district is the fulcrum of all activities in Uttar Pradesh.

Another weak area is that there is no reliable health information system. The only source of comprehensive data is the census, but data sets are very old. There is a need to collect data on a continuous basis on some select key indicators. Convergence models have to take into account information needs and establish systems to collect information. Every panchayat should know exactly how many children were born, how many died and the causes of death. There should be a district-level resource team to collect and analyze this information from lower levels. Sharing information to make meaningful decisions again calls for convergence. For instance, the Department of Education has about 120,000 primary schools and nearly five lakh teachers dispersed throughout the state. They are a major resource that could be utilized in a convergence process.

At the village level, there should be a health committee with a pradhan, ANM, multi-purpose worker, and teachers as members. This committee would review the health status and set its own objectives. There is also a need to conduct health *melas* at the block level. Linkages should be established between the village health committees and the PHCs. This type of convergence model will go a long way in improving the health status of men, women, and children.

Rural Development Programmes in Uttar Pradesh

Naseem Zaidi

In Uttar Pradesh, about 80 percent of the population lives in rural areas, and hence rural development means development of the state itself. According to the latest survey conducted by the Government of India in 1998–1999, nearly 7.5 million families, or 37 percent of rural population, live below the poverty line (income of less than Rs 13,000 per family per year). Rural areas, compared to urban areas, are characterized by low income, widespread poverty, rapid population growth and consequential inequality and unemployment. Rural development has three essential thrust areas: (1) transformation or increase in rural productivity; (2) well-being of rural people, including health, nutrition, education, etc.; and (3) empowerment of neglected classes.

Two strategies have been followed for rural development, which included the trickle-down approach and direct attack on poverty. During initial stages, emphasis was on

community development; later, with the introduction of Integrated Rural Development Programmes (IRDP), emphasis shifted to the generation of employment opportunities. Experiences in the past two decades have shown that IRDP suffered from drawbacks, such as being unwieldy, over-ambitious and poorly designed in lacking proper linkages. In light of the experiences now gained, emphasis on rural development includes the following:

- Implementing rural development at local and community levels
- Involving stakeholders in the development and execution of projects at all stages
- Delivering rural financial services to the poor through the creation of small organizations called self-help groups (SHG)
- Involving the private sector in providing infrastructure and other services
- Promoting community-based management of local resources

The schemes under poverty alleviation programmes have been restructured by the Government of India to improve performance as per recommendations of the Hashim Committee constituted by the Planning Commission. All these schemes can be classified into four groups:

1. *Wage-employment programme:* Employment Assurance Scheme (EAS)
2. *Self-employment programme:* Swarn Jayanti Gram Swarozgar Yojana (SGSY)
3. *Rural housing programme:* Indira Awas Yojana, Credit cum Subsidy Scheme of Rural Housing and Samagra Awas Yojana
4. *Rural infrastructure:* Jawahar Gram Samridhi Yojana, Rural Water Supply Programme

Empowerment of Women under Rural Development Programmes: provision of empowerment of women have been made specifically in all the important rural development programmes. These provisions are:

IRDP: under this scheme, 40 percent of beneficiaries should be women;
Development of Women and Children in Rural Areas (DWCRA): women are organized into SHGs;
Training of Youth for Self-Employment (TRYSEM): of the total trainees covered, 40 percent should be women;
Jawahar Rojgar Yojana (JRY): 30 percent of wage employment opportunities were reserved for women;
Equal Wages for Men and Women: a provision for equal wages for equal work exists for women in all the wage employment programmes;
Jawahar Gram Samridhi Yojana: 30 percent of employment opportunities have been reserved for women;
India Awaas Yojana (IAY): houses constructed for the poor are allotted specifically in the name of the wife or of both husband and wife;
SGSY: under this new scheme, 50 percent of all the SHGs formed will belong to women exclusively, and 40 percent of total Swarozgaris will be women;
Sanitary Toilets: under this scheme, women section of the society is benefited most;
Safe Drinking Water: supply of safe drinking water is also helping women; and
Reservation in Panchayati Raj Institutions: in all panchayati raj institutions, provisions have already been made to reserve 30 percent of the seats for women.

As a result of these development programmes, there has been a decline in rural poverty in Uttar Pradesh from 42.3 percent in 1993–1994 to 36.9 percent in 1998–1999. The pace of decline is, however, slow. Further improvement in the effectiveness of programmes will depend on the involvement of people at the local level in programme implementation, selection of projects based on local needs and demand, and development of strong community-based local institutions.

To further strengthen programmes of poverty alleviation, the following measures are needed immediately:

- Formulation of a unified policy of rural development
- Decentralized planning for all rural development programmes
- Involvement of other sectors, such as panchayati raj institutions, cooperatives, NGOs, and the private sector
- Professional management of rural development programmes
- Restructuring of rural development programmes to avoid multiplicity and conflicting objectives
- Strengthening mechanisms to target poor and eliminate non-poor beneficiaries
- Liberalization of rural economy by promoting micro-financing through self-help groups

ICDS Programme in Uttar Pradesh

Krishna Gopal

The ICDS programme symbolizes India's commitment to its children. The ICDS is designed to promote the holistic development of children under six years of age. Besides specific nutrition and health interventions, an intervention of pre-school education (for 3–6 years) is also built into the programme. The ICDS programme also covers women, particularly expectant and nursing mothers, and adolescent girls. The programme was launched in Uttar Pradesh in 1975, and a full pledged Directorate of Child Development Services and Nutrition was created in 1988. At the state level, a separate Department of Women and Child Development was created in 1989.

Nutritional Status of Women and Children. Malnutrition is no longer considered an outcome of food deficiency or a health

Nutritional Status of Women in Uttar Pradesh

Region	BMI<16.0 (severely malnourished)	BMI < 18.5 (Malnourished)	Height < 145cms	Weight <45 Kg
Eastern	7.9	36.6	19.9	60.7
Central	4.5	27.9	14.9	46.6
Western	3.1	23.4	10.5	41.2
Hills	5.0	32.4	12.1	48.9
Bundelkhand	2.4	23.3	11.8	45.7
Total UP	4.8	29.0	14.3	49.1

Nutritional Status of Children in Uttar Pradesh

Region	Weight for age		Height for age		Weight for Height	
	Severely malnourished	Mal-Nourished	Severely malnourished	Mal-nourished	Severely malnourished	Mal-nourished
Eastern	28.6	57.8	50.5	68.5	11.4	24.0
Central	22.2	54.6	43.3	62.9	10.1	23.1
Western	19.0	45.5	39.9	61.4	7.9	20.6
Hills	18.5	48.6	34.3	61.4	8.6	23.5
Bundelkhand	14.2	39.6	37.9	60.6	5.6	15.2
Total UP	21.2	48.5	42.3	63.4	8.9	21.3

problem, but a multi-dimensional problem, interfacing with all efforts of developing human resources. The nutritional status is closely linked to food security, level of poverty, status women, growth rate of the population and access to health, education, safe drinking water, and other social services. A detailed study on the nutritional status of currently married women in reproductive age conducted in 1995 revealed that 29 percent of women in Uttar Pradesh were malnourished and had a Body Mass Index (BMI) below 18.5; 4.8 percent suffer from severe malnutrition and have a BMI below 16.0. The percentage of women with height below 145 cms was 14.3 percent and of those with weight below 45 kgs was 49.1 percent in the state.

Results of nutritional status among children revealed that 48.5 percent of children in the state was underweight, 63.4 percent stunted and 21.3 percent wasted. The state-level percentages of severely malnourished children in the underweight, stunted, and wasted ranges were 21.2 percent, 42.3 percent and 8.9 percent, respectively. Among all regions in the state, women and children in the Eastern region were most malnourished. In addition, almost every district of the Eastern region had relatively more malnutrition. Rural areas had more malnourished women and children compared to urban areas.

Coverage of ICDS Programme in Uttar Pradesh. At present, the central or state Government has sanctioned 550 ICDS projects in Uttar Pradesh. The ICDS programme is operational in 550 blocks of the state spread over 80 districts. A total of 53,699 *anganwadi centres* are functioning in the 550 ICDS projects operating in the state. Entire administrative expenses of the ICDS programme are borne by the Government of India, whereas supplementary nutrition is being arranged by the state Government. At present, in 226 projects, raw materials for the supplementary nutrition are provided free by agencies like CARE and the World Food Programme. In these projects, only processing and transportation expenses are borne by the state. In the remaining 324 projects, all the expenses incurred on supplementary nutrition are borne by the state. In all, the ICDS benefits 45.25 lakh women and children in the state.

At the state level, the ICDS programme is coordinated by the ICDS Directorate, headed by the director. At the district level, implementation of ICDS programme is coordinated by a District Programme Officer. Each project is headed by a Child Development Project Officer, who has *mukhya sevikas* (supervisors) under him. Each supervisor is responsible for supervising 20–25 anganwadi centres, and each centre has one anganwadi worker and helper. The main services provided there include supplementary nutrition, growth and weight monitoring, immunization services, and pre-school education.

Despite efforts of the ICDS programme in the past 20 years, much remains to be accomplished. The following issues deserve attention in an attempt to improve the programme effectiveness:

- There is a definite need to sensitize the community, especially its leaders, about the goals and objectives of the ICDS programme. An intensive awareness campaign must be conducted before opening an anganwadi centre in any area, and the views of the local people must be taken into consideration before finalizing its location.
- At present, intersectoral linkages remain relatively weak and require strengthening. In particular, linkages between the anganwadi centre, primary health center, and primary school must be strengthened.
- The present state of the training of various ICDS functionaries in the state leaves much to be desired. Besides the definite and urgent need to bring about a qualitative improvement in training, a proper training monitoring system should be developed and implemented on priority basis.
- In more than 95 percent of the anganwadi centres in the rural areas, neither adequate space nor proper buildings are available. As part of World Bank assistance, it is proposed to construct 4,000 centres and 150 child development project offices cum warehouses, which covers less than 10 percent of anganwadi centres.

Discussant

Saurav Chandra

The first paper discussed the outlays that basically reflect the plan priorities. Although the outlay for various sectors has gone up, money allocated to social sectors is not commensurate to needs. The paper also dealt with performance data; one sector influences the other. How to break this vicious circle is something that must be discussed. The idea of a health plan is good, but does there exist a will to develop and implement such a plan at the district level? There is a technological component and a managerial component to the programme implementation. We need to pay more attention to the managerial component to achieve intersectoral coordination. Involvement of teachers is critical to the programme. Teachers are natural opinion leaders. Several development programmes are being implemented at present. For instance, self help groups have so much potential. The ICDS could be a very effective vehicle for promoting family planning. There are also some internal constraints that have to identified, articulated, and overcome to make the family welfare programme a major success.

Discussant

Bachchi Lal

The first paper discussed investment in the national health sector, both for health and family welfare. If we take both the Government of India and Uttar Pradesh Government investments in this sector, the investment has declined over time. If we analyze the investments in terms of the salary and non-salary components, nearly 90 percent of the money earmarked for family welfare goes to pay salaries. Funds available to components of the programme, other than salaries, are meagre. Ideally, 10 percent of total funds should be allocated to health sector; however, now the total allocation is less than 3 percent.

The CNA approach is a strategy to develop the action plans at all levels using a bottom-up approach. However, detailed guidelines on how to prepare these plans have yet to be issued to different levels. Involvement of panchayati raj institutions is another important issue. They have used the meagre resources made available to them by preparing their own plans. In rural areas, nearly 30 percent of population does not have access to services. The RCH camp and health *mela* approach should be considered as alternatives. Under the RCH and SIFPSA projects, we are catering to the unserved population.

The second paper on rural development has provided vivid descriptions of various programmes. Panchayats can be effectively involved in the planning process. They can also be involved in programme monitoring by the community. At present, no attempt has been made in this direction. There are no health workers in the department now; they all have become village panchayat development officers. Out of a total of 20,000 subcentres, only 30 percent are in Government buildings. Some health workers do not stay at the place of their posting. If the panchayats are interested, the workers will be compelled to stay at the place of their posting. Committees at various levels should have representatives from the private sector, particularly NGOs. Panchayats should be used not only for implementation of various programmes, but also for creating awareness among the community.

Discussant

A. K. Das

The paper on the intersectoral approach talked about horizontal integration of certain programmes and emphasized the importance of taking holistic view of all the developmental schemes. We have not yet attempted to have integrated systems during campaigns. Convergence at the grassroots level is important because the family welfare programme for the past 40 years worked in isolation. The Health and Family Welfare Department alone cannot solve population issues. There is a vertical approach for every development activity in the country, and each department has a compartmentalized approach. Sometimes various departments are pursuing the same goals; for instance, the Women and Child Development and Health and Family Welfare departments have been pursuing the same goals. We need to move from a programme-based approach to a sector-wide approach. For convergence, the same messages should be given and panchayati raj institutions should act as agencies to coordinate activities.

SESSION VII

ADVOCACY AND MEDIA

Chairperson: *Yogendra Narain*

Facilitators: *V.K. Dewan*
Gyanendra Sharma
Udai Sinha
Gadde Narayana

Session VII

Advocacy and Media

Yogendra Narain

Uttar Pradesh is a state with considerable variations between regions. Population policy for RCH, therefore, should take these regional variations into consideration. Normally, for purposes of planning any activity, five different regions are taken into account: Purvanchal (eastern Uttar Pradesh), Bundelkhand (Jhansi Division and Chitrakoot), Madhyanchal (central Uttar Pradesh), and Paschimanchal (western Uttar Pradesh) and Uttarakhand (hills). These regions vary not in terms of economic development but in terms of social development indicators, such as literacy, status of women, and other quality of life indicators. Uttar Pradesh has started preparing a human development report with the assistance from UNDP, which will be ready by July this year. We have taken into consideration regional differences to prepare the report. It is therefore necessary to differentiate between different regions and come out with different policies for different areas.

Another point that needs to be considered based on the NFHS II results is the preference for male children. Earlier, it was thought that the fertility was high because every one wanted a male child; but the survey results indicated that there was a remarkable improvement in the sex ratio. In the 1991 census, the sex ratio was 881, increasing to 927 in 1998–1999. Thus, the girl child is not unwanted. What impact this may have on the family planning programme is for the experts to discuss and decide. The changes taking place in the state have to be considered while formulating the population policy.

V. K. Dewan

Uttar Pradesh has several projects. In areas where SIFPSA has been implementing the IFPS Project, the contraceptive prevalence rate is 5–7 percent higher than areas where SIFPSA has no significant presence. The SIFPSA is working only in a few districts, but the Family Welfare Department is concerned with the whole state. For other districts, however, we have the RCH Project, sponsored by the government of India.

We are trying to ensure that efforts of the RCH Project are not duplicated in districts managed by SIFPSA. We are trying to plug all critical gaps in providing MCH services, which have direct or indirect bearing on population stabilization efforts. Gender issues will be discussed later; however, the major gender issue that has come up during earlier discussions was "son preference." There are variations within state on gender-related

issues. The Hills region is different because there the acceptance of family planning is very high, infant mortality is low, and immunization coverage is high. But in areas adjoining Nepal and central and eastern Uttar Pradesh, contraceptive prevalence is low and infant mortality is high. In Bundelkhand, family planning acceptance is very high, and in the state itself, there are different geographical locations with wide variations regarding the acceptance of family planning and other development indicators. Family welfare cannot be seen in isolation; attitudinal changes need to occur, which cannot be brought about by one department. It needs support from panchayati raj institutions and the ICDS, education, and other departments. We hope that the issues discussed here will help us formulate a viable population policy.

Gyanendra Sharma

After a gap of many years, we are hearing good news on the population front, which is significant. The NFHS II has revealed that our progress in the last six years is almost equal to what we achieved in the previous 40 years. The average number of children per family has been reduced to four and the couple protection rate has increased by 40 percent. At a time when the entire country in general, and Uttar Pradesh in particular, is facing problems resulting from increasing population, this achievement cannot be considered small. Although scholars have already discussed and analyzed the data in this regard, I would like to give some suggestions.

A number of findings of the NFHS are significant. One such finding is that 100 percent of women in urban areas and 98 percent in rural areas are aware of family planning methods. This means we no longer have to tell people about family planning methods. Increased awareness could be due to intense publicity campaigns conducted last year. We need to convince people about the need for family planning. Workers should tell women why the mother of few children is likely to be healthier than the mother who has many children. In a household, men play a dominating role and make all the decisions. Wives have to accept the decisions of their male counterparts. There is also a need to understand why men, knowing full well the importance of small family size, often tend to ignore that fact. In order to establish dialogue with men, a sensitive and perseverant approach is needed. All IEC activities have to be oriented toward this. If the husband is ready to have a small family, no one can be happier than his wife.

More often than not, in our enthusiasm to motivate couples, we do not pay attention to unmarried youth. As educators, our task becomes easy when youth get married and start family life. We also often talk about political will. During the Emergency, when family planning was strictly implemented, many political parties had to suffer. Those who were sitting in opposition at that time made political capital out of it. Those same people are now in power. They feel that the programme is beneficial to people and want to implement the same programme. It is not a just a question of political will, but a serious analysis of political dynamics is needed.

For example, in 1985 the government initiated a green card scheme in Uttar Pradesh. The

scheme provided facilities to those who adopted family planning after having only two children. There were a given number of facilities, such as concessions in land revenue, admission to schools and colleges, plots, government employment, loans, and so forth. Where has this scheme gone? Who is responsible for its disappearance? When we talk about political will, we need to discuss bureaucratic will as well. This scheme could not succeed due to lack of coordination among various government departments. Thus, a good effort initiated 15 years ago could not take off.

Another important point is that the family planning programme has been considered as a government programme. It has all the ingredients of any government programme. According to a survey conducted by SIFPSA, dependence of people on government programmes was declining. In places like Ghaziabad and Meerut, only 15–20 percent are getting the benefits of government facilities. More people are going to private hospitals and private doctors because they know that government health facilities are poorly managed. Therefore, it is necessary that the family planning programme be freed from government control as soon as possible. It is only then that people begin to derive any benefit from the programme.

For family planning advocacy, two media are necessary. First is propaganda and second is publicity by word of mouth. Word of mouth is the most powerful weapon. You do not have to pay for it, but at the same time, it is most effective. But the question is how to make use of it. We have to have a strategy for this. Teachers, religious leaders, and opinion leaders can play a major role. One of the major factors that contributed to failure of the family planning programme is illiteracy. All these factors have to be taken into consideration to formulate a policy.

Udai Sinha

Since we talk to people in cities and villages, we have a wider canvas of experience. Containment of population growth is not merely going to occur through the use of contraceptive methods. It basically has to do with the attitudes of people. When Gyanendra Sharma said that most of the people have adopted family planning programmes, he is not referring to the rural and urban divide. Adoption of family planning is directly related to female literacy, the status of women, and the infant mortality rate. Why do people of the lower stratum of society have more children than people from the upper stratum or those who are educated? For the poor, having more children provides a sense of security, mainly because of the economic hardship they face.

Here is an illustration. I asked the housemaid working in my house the number of children she has given birth to. She said six. Her age was 34. Her youngest child was one year and her eldest daughter, who helps her do household jobs, is 7 years. They were earning Rs 2,200 every month, out of which only Rs 700 was earned by her and the remainder by her daughter. Shall we expect her to adopt family planning? In addition to this, it is very important to look into child survival chances, particularly in rural areas where health facilities are not available; and if available, they do not work. These are some of the issues that we need to address.

How to make the family planning programme successful? IEC will solve most of the problems. Targets have been abolished and should not be reintroduced. Female drop out rates should be reduced considerably. Advocacy has to be accomplished in the schools, health institutions, and within families. Young family members also act as a pressure group. If experts could think along these lines, society would benefit. As far as media are concerned, print media reach only 3 percent of the population. It is better to depend on an audio-visual campaign than print media.

Yogendra Narain

Udai Sinha has rightly emphasized the economic status of women and their education. Recently, we carried out an educational survey and found that the female dropout rate decreased by almost 30 percent in the last three to four years in Uttar Pradesh. This survey was done as part of the World Bank programme, in which we are establishing and examining schools in villages. We have got an intensive primary education programme in Uttar Pradesh covering all the districts.

As far as the status of women is concerned, we have a 30 percent reservation for women for the post of pradhans in the panchayats. Originally, pradhan patis ruled the roost for quite some time. Now we are finding that lady pradhans have advanced on their own. Decision making by women is increasing in the state.

Gadde Narayana

The common factor in the discussion here is that the programme should be outside the government system. A second important point that is emerging is the creation of political will to formulate and implement policies effectively. The third issue is religious and influential people spreading the message by word of mouth. Print media have a limited role in spreading the messages because their reach is limited. However, print media have an important role, particularly in creating political will in state population programmes.

Change in fertility behaviour is closely linked to the status of women, empowerment of women, and economic independence of women. There are tremendous variations in all these aspects in different regions of Uttar Pradesh. How we address these variations from a policy point of view needs some focus and debate. People in general are dependent on the private sector for spacing methods, such as oral pills and condoms, but the government health institutions still play a major role in providing services to acceptors of permanent methods. There was also a mention of the green card and incentives for the family planning programme. I would like to point out that 20 percent of the married women in Uttar Pradesh who are not using any family planning method are keen to use one. If the programme is able to reach out to these women, there will be no need to introduce incentives.

SESSION VIII

ROLE OF NON-GOVERNMENTAL ORGANIZATIONS IN UTTAR PRADESH

Chairperson: *Ms. Kristin Loken*

Role of NGOs in RCH Programme
Marta Levitt Dayal

Involving Milk cooperatives in the Family Welfare Programme in Uttar Pradesh
R.C. Awasthi

Role of the Organized Sector in the Family Welfare Programme in Uttar Pradesh
C.B. Tiwari

Discussants: *Rajeev Kumar Singh and Rakesh Kumar*

Session VIII

Role of Non-Governmental Organizations in Uttar Pradesh

This session has three papers dealing with NGOs. The first paper is on policy issues associated with NGO participation in programme implementation. The other two papers deal with the role of the organized sector and the experiences of dairy cooperatives.

Remarks of Chairperson

Kristin Loken

As the Chief Secretary just mentioned, we are answering the question of how to transform the programme into practice and further integrate private sector activities into family welfare programmes. The Government's role is critical in achieving family planning and reproductive health objectives; however, private sector must be involved in order to meet the objectives.

The Role of NGOs in RCH Services: Policy and Partnership Implications for Uttar Pradesh

Marta Levitt Dayal

As we enter the new millennium, we will look back on the unprecedented global population growth during the last 100 years, exploding from a population of a mere 2 billion to 6 billion. The enormous task of ensuring the rights of each and every individual's access to reproductive health services will require efforts beyond what Governments alone can provide. The 1994 ICPD formulated the *Programme of Action* for the next 20 years that clearly mandates that NGOs should play a significant role in improving reproductive health and ensuring reproductive rights.

NGOs throughout the world have rallied to the call, in partnership with Governments and independently, to increase access, improve quality, and create demand for RCH services. NGO contributions have been most significant in meeting information and service delivery needs of communities and groups historically unserved or underserved by the public sector. Given their physical and socio-cultural roots in communities, NGOs have been instrumental in shifting the attention of RCH programmes away from mere physical access to health facilities to the creation of enabling environments and socio-cultural access for

behaviour change. The inherent flexibility of NGOs has led to the development and testing of innovative models for service delivery, demand generation and social mobilization, which have been replicated and expanded on national and global scales. Finally, NGOs have played a pivotal role in advocating for clients' reproductive rights and for Governments to provide reproductive health programmes and services. NGOs clearly have very significant and unique advantages and strengths in providing reproductive health services in that they are autonomous, less bureaucratic, and thus more able to be flexible and responsive to local needs.

NGOs and RCH in India. In response to the framework set down by the ICPD *Programme of Action,* India formulated a national RCH policy under the 9th Five-year Plan that signaled a landmark shift from a target-driven to a target-free approach, which is client-centered, based on informed choice, and provides high-quality and integrated RCH services. The Government of India has been involving NGOs in family welfare schemes since the early 1980s. Recently, it has been estimated that there are 25,000 active NGOs in the country and approximately 12,000 involved in reproductive health. Under the current 9th Five-year Plan, 600 NGOs are being supported by various programmes under the Ministry of Health and Family Welfare. Within the national RCH policy, specific roles have been outlined and provisions made for participation of the following three categories of NGOs:

- Small NGOs are involved at the village, panchayat, and block levels to advocate and provide counseling for RCH and family
- Mother NGOs, those with substantial resources and demonstrated competence, are provided grants to cover 5–10 districts for the support of small NGOs. This support includes proposal development, sub-grants, training, technical assistance, and monitoring.
- National NGOs are being assisted on a project basis to design and implement innovative RCH programmes and run mobile clinics. Select national NGOs are responsible for monitoring and performance assessment of Mother NGOs.

Role of NGOs in RCH and the IFPS Project. In 1992, prior to the initiation of the IFPS Project, the NGO sector in Uttar Pradesh was particularly weak. According to one estimate, 552 Private Voluntary Organizations (PVOs) existed in Uttar Pradesh. Another estimate quoted that there were 400 health-oriented organizations active there. The IFPS Project covers 29 districts of Uttar Pradesh. The number of private sector projects—NGOs, dairy cooperatives, employer sector—supported by SIFPSA has grown from three to 173 in 2000—in 23 districts. Significant NGO contributions to the project are the creation of 4,500 new service delivery points through the training of community health workers and an increase in regular client contact and follow-up. A survey of 8,500 women found that 80 percent had met with a community health worker (CHW) and 88 percent met at least once a month. Another success has been the increased method mix and use of temporary methods. A client survey in January 1999 found that in the first four years of the IFPS Project, NGO projects in 15 districts were responsible for 462,000 new acceptors. Of

these, 170,000 were from 1998 alone. Furthermore, it was found that the contraceptive prevalence rate for spacing methods doubled from 3.7 to 7.2 percent in 3.5 years. Currently, the private sector serves 822,439 users of spacing methods.

Issues for NGOs Providing RCH Services

1. *Costs.* It is often argued that NGO/RCH projects are cost-intensive; however, analyses of NGO community-based distribution projects in developing countries provide definitive evidence that the community-based distribution approach used by many NGOs is more cost-effective than clinic-based projects.
2. *Geographic Coverage.* Another concern regarding NGOs is that their coverage is limited and thus their impact on overall fertility decline and population stabilization is limited. However, the IFPS Project has been able to partner with a significant number of NGOs including those that cover large geographic areas.
3. *Sustainability.* One of the most important emerging issues is that of sustainability for reproductive health services resulting from NGO programme efforts. The IFPS Project found that through dialogue and training, willingness to introduce sustainability measures increases and that many organizations take it on as a positive challenge towards attaining self-reliance.
4. *Coordination.* With increasing numbers of NGOs getting involved in reproductive health, it is necessary to coordinate and literally map out areas of service delivery to avoid overlap.
5. *Transparency and Accountability.* Given that NGOs are entrusted with the general development for communities in which they work, public demand for transparency and accountability in the NGO sector has increased significantly in recent years. NGOs must be able to account for their work, results and appropriate use of resources.
6. *Decentralization and Reporting of Service Statistics.* Establishing or reporting through a good MIS is critical for NGOs to ensure that their efforts are recognized and documented. Well-documented or showcased NGO projects have greater chances of securing funding, and thus documentation is imperative for sustainability considerations.
7. *Institutional Strengthening and Capacity Building.* For effective participation of NGOs in RCH, NGOs require strengthening at two levels—strengthening of institutions and capacity building of human resources. Facility and infrastructure upgrading, management and training systems development, training of staff, technical assistance during implementation, and strengthening of the organization as a whole are prerequisites for successful projects to show quick results.

Despite their significant successes, NGOs in India face certain challenges in providing RCH services. The main areas of concern are: regular supply of commodities, resource allocation for NGO participation in RCH, involvement of policy formulation and strategic planning, lack of information on available resources for NGOs, and preserving the autonomy of Mother NGOs.

Recommended Strategies for Improving Impact of NGO/RCH Services

1. Involve NGOs at all levels of programme planning and implementation making full use of each NGO's unique set of experiences and capacities.
2. Establish a system to coordinate and literally map out NGO activities to reduce overlap and avoid gaps in service delivery.
3. Create a coordination network of NGOs at state and district levels for NGOs to coordinate activities.
4. Indicators for NGO projects need to be results-oriented with specific indicators to measure a few key desired RH behaviour changes, the quality of services, and provider performance.
5. Develop clear criteria for selecting NGO partners and a system for involving diverse stakeholders in the proposal review and approval process.
6. Encourage NGOs to be more financially self-reliant and to find a means of maintaining a corpus fund.
7. Specific sustainability plans and measures should be built into project design with policies on time limits for financial support to NGO efforts in any one location.
8. Introduce an effective system that documents NGO contributions to project, district, and state reproductive health efforts.

Involving Milk Cooperatives in the Family Welfare Programme in Uttar Pradesh

R. C. Awasthi

In Uttar Pradesh, the size of agricultural land holdings is declining sharply with the increase in family size. As a result, earning a livelihood from agriculture has become limited. It is dairy that is providing additional income to small and marginal farmers and also to the landless. Milk cooperatives are associations of like-minded individuals, who voluntarily form a society to eliminate middle-men and promote the production of milk and sale of their produce. The main aim of milk cooperatives is to improve the business skill and standard of life of its members.

Milk cooperatives possess a three-tier structure starting from the village to the state level. Village-level Primary Cooperative Societies are managed by members who form an elected management committee. These village-level societies are affiliated with the district-level Milk Union to get better market for their produce. District-level milk unions are federated into a State-level Dairy Federation, which provides specialized and technical services to its member unions.

The Pradeshik Cooperative Dairy Federation (PCDF) was established in 1961 after the success of the cooperative movement in Gujarat. The PCDF had 6,124 dairy societies in 1991–1992, and this number increased to 10,619 societies in 1999-2000. Likewise, the number of dairy society members increased from 343,000 in 1991–1992 to 558,885 in 1999–2000. The federation has incorporated several schemes to improve the quality of life of its members. Some of its ongoing projects include provision of vehicles for milk transportation, group insurance for milk producers, education, gender sensitization, organization of exclusive mahila (women) socities, and loans to its members. The milk cooperatives have become a force, covering 83 districts

through 63 milk unions. Initially, the PCDF received support from SIFPSA for a pilot project. The main objective of this project was to develop an effective, sustainable, replicable, and culturally appropriate model for family planning and RCH services based on the community-based distribution approach. The pilot project was implemented in Meerut and Sitapur districts, covering a total of 65 cooperative societies. The rapid assessment conducted by external agencies at the end of the project demonstrated considerable increase in contraceptive method use in the project area. The project recruited women health volunteers from among village women. Preference is given to women who have completed at least five years of schooling, are married, a resident of the village, and currently use a method of family planning. These volunteers, after training, regularly contact women, provide information and services, organize immunization camps, and distribute IEC material.

After successful implementation of initial pilot project, the model has been replicated in eight more districts of the PCDF and six districts of the Milk Board. Currently, the projects cover 5,400 villages and provide services to 480,000 clients.

Role of the Organized Sector in the Family Welfare Programme in Uttar Pradesh

C. B. Tiwari

Natural resources are bound to become depleted and ultimately exhausted; hence, humankind must be very judicious in using them. Population, often referred to as a human resource, is one resource that will never deplete, thus the apparent contradiction of society needing to decelerate the growth of this resource. Population is the greatest resource that any institution or state can use most fruitfully. This is a unique resource that is both "producer" and "consumer." Unfortunately in the context of India, this resource has turned out to be a liability as it is less of a producer and more of a consumer.

The corporate houses during the post-independence period felt that welfare measures like health and population were strictly the business of Government. However, gradually a number of companies realized the importance of socioeconomic development of the area where the manufacturing units were located. J. R. D. Tata once said, "What comes from the people has to go back to the people many times over." Tata Steel adopted the tribals of Bhalubasa, a village near Jamshedpur, to form a cooperative and increase the earning capacity of the tribals by honing their cane-weaving skills and finding a market for their produce. Another example of social responsibility of the corporate sector comes from Aditya Birla Group, which is very active in improving the quality of life of its people. The Director of the A. V. Birla Group once stated, "We have always believed and continue to foster the trusteeship concept of management. We are committed to plough back part of our funds to make meaningful difference to peoples' lives." The organized sector, which is committed to the socioeconomic development of people, is certainly well placed to play an important role in the family welfare programme.

Potential of Organized Sector to Yield Results. Before we actually understand what

role the organized sector corporate houses can play, it is necessary to understand the strengths of the organized sector vis-à-vis the welfare agencies of the Government. The organized sector, especially the well-run corporate houses, have the following strengths:

- *Management Skills and Expertise.* Each of the business units in the organized sector has survived because of its management skills and expertise. Over time, managers not only sharpened their skills but also developed new ones.
- *Accountability.* One of the main reasons for the success of the organized sector is the accountability of its individual managers for all success and failure which, in turn, is linked to reward and punishment.
- *Leadership.* Continuity in leadership ensures consistency in approach. This in turn helps to achieve the goals and objectives of the enterprise.
- *Capacity to Respond to Changes.* Management expertise, accountability, and continuity in leadership facilitates the organized sector to quickly respond to changes in the environment.
- *Compactness.* The compact size of the business units in the organized sector as compared to the monolithic structure of the Government gives a distinct advantage to the organized sector.

Mother and Child Welfare Project. Indo Gulf Corporation, under the aegis of Indo Gulf Jan Seva Trust, took up a Mother and Child Welfare Project in collaboration with SIFPSA, initially for three years. Commencing in April 1998, the entire Jagdispur Industrial Area and 23 panchayats in Jamo Development Block were selected for project implementation. Baseline surveys conducted in the beginning of the project revealed that RCH services were inadequate in the area and 63 percent of pregnant women had not received antenatal care. Nearly 85 percent of deliveries were conducted at home. More than one-half of the children did not receive vaccinations, and the infant mortality rate was very high. The number of couples using contraceptive methods was very low.

Several activities were undertaken in the project area, including household visits by volunteers, village-level clinics, panchayat-level camps, group meetings, audio-video shows, folk media cultural shows, awareness camps and seminars. As a result of these efforts, the contraceptive prevalence rate in rural areas in two years increased from 11 to 22 percent; in the industrial sector the increase was from 45 to 65 percent, and in the project areas the increase was from 18 to 30 percent. This project definitely proved that the organized sector, in collaboration with other agencies, could play a vital role in improving the quality of life of people.

Discussant

Rakesh Kumar

SIFPSA's experience with NGOs, the organized sector, and cooperatives is very encouraging and successful. The first paper on the NGO sector dealt with the history of NGOs, their involvement in family welfare programmes, and the ICPD agenda and *Programme of Action.* The community-based distribution model adopted by NGOs is very successful. NGOs also carried out IEC activities and created a conducive environment for implementation of programmes. However,

there are a few questions that remain. Are the NGO projects cost effective? Are they sustainable? Can they provide access to services to a large proportion of population? Coordination with the health department, transparency, and accountability are some of the weak points. SIFPSA has been working with 90 NGOs, and specific objectives were identified for each project. The SO2 Indicator Survey, conducted by the POLICY Project, revealed that the spacing method use in districts with SIFPSA-funded NGO projects increased considerably.

The organized sector, due to its managerial skills, transparency, and accountability, is in a better position to respond to changes in the environment. It acts as a role model, as a catalyst, and as a facilitator. SIFPSA is trying to involve as many industrial units as possible in family welfare sector. In the cooperative sector, SIFPSA funded 18 projects. Two pilot projects were implemented and, after their successful implementation, more cooperative projects were sanctioned. The strength of these dairy projects is obvious, particularly in terms of the infrastructure available, organized to the village level, and continuous interactions with the community members. Women are actively associated with milk cooperatives and this is a positive aspect.

Discussant

Rajeev Kumar Singh

In ancient times, kings and rich landlords used to make dharmashalas and construct wells and ponds for the benefit of common people. Earlier, it was the concept of charity. Over time, it has changed to the concept of voluntary work. NGOs played a major role in community mobilization, family planning and other national health programmes. SIFPSA funded several NGO projects, and this has considerably improved the image of NGOs. There are two types of SIFPSA-funded NGO projects: (1) clinical; and (2) non-clinical. In Varanasi, we are working on a non-clinical project. Initially, we had to face a lot of problems as ANMs and other grassroot-level workers considered us as rivals. As they did not cooperate with us, the pace of progress was very slow. Still, there are many problems. NGOs excessively dependent on Government sector for service delivery have to face several problems. So there is a need to make NGOs self-sufficient.

NGOs played a significant role in initiating innovations. Initially, we were considered as distributors of oral pills and condoms. But gradually we changed the perceptions of people by integrating various development activities such as rural development schemes, adult education programme, women's empowerment, and income-generation activities. This improved the image and also the acceptance of NGOs. There is a strong need for convergence of various development and social welfare activities adopting a holistic approach. Now we have only external evaluation and quarterly reports. It is necessary that NGOs have a self-evaluation system. This will improve their performance.

SESSION IX

GENDER ISSUES, ADVOCACY, AND INFORMED CHOICE

Chairperson: *Aradhana Johri*

Status of Women in Uttar Pradesh: Empowerment of Women
Sumati Kulkarni

Informed Choice and Contraceptive Technology
Jyoti Vajpayee

Role of Advocacy in Reproductive and Child Health Services
Marta Levitt Dayal

Session IX

Gender Issues, Advocacy, and Informed Choice

Status of women, gender issues in service delivery, and safe and reliable contraceptive technologies available determine the contraceptive and fertility behaviour. Advocacy has an important role to play at all levels of programme management. These issues are discussed in detail in this session.

Remarks of Chairperson

Aradhana Johri

Subordination of women in the family and society results in slow process of development. Improvement in quality of life is difficult to achieve without improvement in status of women. All programmes, irrespective of their objectives, should address the issues related to women and all policies should protect the interests of women and empower them. Recent survey results provide interesting insights into status of women in Uttar Pradesh particularly their role in decision making. Several new contraceptive technologies, which are safer and reliable, are available now. Enlarging the contraceptive choice by introducing appropriate technologies into the programme will improve the contraceptive use among men and women. Advocacy is the core theme of all efforts we make to improve the programme performance.

Status of Women in Uttar Pradesh and need for Women's Empowerment

Sumati Kulkarni

Enhancement of women's status has been recognized in India as a goal by itself ever since the 19th century, and many social reformers have dedicated their life to this cause. It was only in the mid-1970s that it came to be viewed as a means to an end (i.e., a mechanism to accelerate the fertility transition in India). The concept of gender-adjusted human development index, Swaminathan Committee's recommendation for a pro-women, pro-poor and pro-nature population policy, and adoption of a comprehensive RCH approach by India after the ICPD are important developments that helped put gender issues in greater perspective. The issue is whether all these developments have been able to "break through the embedded hard rock of patriarchal power"—the root cause of the low status of women in India? Whether all the work on women's status is confined to only

ideological and academic debate or has it made any impact on the lives of women in this country? Has it generated any mechanisms to weaken the forces of patriarchy and empower women? The present paper proposes to address some of these issues on the basis of an analysis of NFHS II data for Uttar Pradesh, the largest state in India.

The status of women is measured in terms of education, exposure of mass media, employment, marriage and cohabitation, the role of women in household decision making, freedom of mobility, access to money, and domestic violence-experience and attitude.

Education, Exposure to Mass Media, and Employment. These three aspects represent women's exposure to and interaction with the outside world. In Uttar Pradesh, 70 percent of women in the NFHS II sample are illiterate, which is in complete contrast to Maharashtra where only 40 percent are illiterate. But Uttar Pradesh is not very different from Andhra Pradesh (64 percent) in this respect. Comparison with NFHS I showed a decline of 6 percentage points in illiteracy among women. More than one-half of the women in Uttar Pradesh are not regularly exposed to any media compared with only one-fourth in Andhra Pradesh. One definite sign of improvement is the decline in the percentage of women not exposed to any media from 65 percent in 1992–1993 to 55 percent in 1998–1999. Nearly three of four women (77 percent) in Uttar Pradesh do not participate in economic activity, compared to only 40 percent in Andhra Pradesh and Maharashtra. The percentage of non-working women declined from 87 percent in 1992–1993 to 77 percent in 1998–1999. On all these criteria, women of Uttar Pradesh have low status compared to women in Andhra Pradesh and Maharashtra.

Marriage and Cohabitation. The median age at first marriage in Uttar Pradesh is about 15, which is three years lower than the legal minimum age at marriage for girls. However, the median age at first cohabitation is slightly higher at 16.4. Andhra Pradesh, although believed to be more modern than Uttar Pradesh, has almost the same marriage pattern as Uttar Pradesh. But due to the absence of *gauna*, the median age at cohabitation is almost one year lower than in Uttar Pradesh. During the last six years, the median age marriage in Uttar Pradesh has not changed at all.

Role in Household Decision Making. In NFHS II, respondents were asked questions as to who in their house makes the decisions regarding cooking, their own health care (going to doctor), purchasing jewelry, and so forth and going to and staying with their parents and siblings. In Uttar Pradesh, 16 percent are not involved in these decisions. The corresponding percentage for Andhra Pradesh and Maharashtra is only 7. In Uttar Pradesh 78 percent are involved in decisions regarding cooking, but hardly 36–44 percent were involved in decisions regarding their own health care, purchasing jewelry, or decisions about staying with their parents or siblings.

Freedom of Mobility. In a society where seclusion of women is ensured and veiling in the presence of elders is common, mobility of women is likely to be highly restricted. As a result, only 17 percent of women reported they do not need permission to go to market.

Only 12 percent do not need permission to visit friends and relatives, which is in sharp contrast to the freedoms enjoyed by 79 percent and 56 percent women in Tamil Nadu.

Access to Money. In a society where nearly 75 percent women are non-working, women are less likely to have direct control over economic resources, but their status in the household can be assessed by finding out whether they have access to some money that they can spend as they wish. It is interesting and encouraging to find that, in spite of low work participation in Uttar Pradesh, one-half of all women have access to money. However, this is 80 percent in Tamil Nadu and 58 percent in Andhra Pradesh.

Domestic Violence—Experience and Attitude. Domestic violence against women in any society not only indicates very low status of women but also has immediate implications for their health status and has serious demographic consequences. One of every five women in Uttar Pradesh as per their own reporting have been beaten or physically mistreated since age 15, mostly by their husbands. Among these, 60 percent were beaten or physically mistreated during the 12 months preceding the survey, revealing a serious situation. However, more serious is the NFHS II finding that nearly 61 percent of women justify the beating of a wife by her husband. In Andhra Pradesh, a still higher percent (80 percent) justifies wife beating.

Analysis of NFHS II data confirms that the status of women in Uttar Pradesh is low in terms of most of the direct and indirect indicators. The situation is far from satisfactory in terms of literacy, work participation, exposure to mass media, and age at marriage; but the major problem is autonomy. Uttar Pradesh reveals a sharp contrast to Tamil Nadu, Maharashtra, and Andhra Pradesh in terms of women's involvement in decision making and freedom of mobility.

In spite of this, there are some encouraging signs. There is definite improvement in recent years in terms of literacy, exposure to mass media, and work participation, but the process is slow. It is a matter of serious concern that age at marriage has not increased at all during last six years. Far greater social inputs are required to accelerate these processes. Far more serious is the situation in regard to domestic violence. More than the actual experience of violence reported by one-fifth of women, the gravity of the problem lies in the large majority who justifies wife beating. Improvement in this scene requires deep-rooted changes to weaken the forces of male domination. This certainly requires not only empowerment of women but changes in the attitude and behaviour of men.

Informed Choice and Contraceptive Technology

Jyoti Vajpayee

The principle of "informed choice" lies at the center of the international reproductive and sexual rights agenda and is a key element of quality in family planning and reproductive health services. Based on principles of autonomy and individual human rights, the informed choice process should ensure that clients make their own decisions regarding family planning and health care and are empowered by information and the service delivery environment to freely exercise their

decision-making right. Informed choice and its more limited but well-known cousin, "informed consent" are fundamental to all health care. Voluntary and informed client choices are necessary components of quality care and individuals who make informed decisions are more likely to be satisfied and to follow through with the chosen method or course of treatment.

Individuals arrive at a service delivery site with varying medical and personal circumstances and with vastly different levels of knowledge about their own health and about options that may exist. They also arrive at various stages of the decision making process. Some are knowledgeable and others may seek more information and guidance. For all individuals, however, the process of informed decision making in the service delivery setting requires some key elements:

- Respect for individual choice and autonomy
- Two-way communication
- Access to comprehensive information
- Real method or treatment options
- Time for questions and reflection
- The right to consider at any time

Informed choice refers to the process by which an individual arrives at a decision about health care. It must be based upon access to, and full understanding of, all necessary information from the client's perspective. When a family planning method or procedure is to be administered by a provider, it is the provider's responsibility to facilitate the informed choice process that helps to define the provider's role in the family planning context.

According to the NFHS II, a vast majority of contraceptive users were not given essential information that is needed to make informed choice. Of the total current users, only 13 percent were told about other methods by the motivator; 14 percent were told about side effects or other problems; and 51 percent received follow up after accepting the current method.

Contraceptive Technology. From marriage to first birth, the primary fertility goal is to postpone pregnancy and childbirth. Between the first and last births, the primary goal is to space childbearing. Between the last birth and menopause, the goal is cease childbearing altogether. The best method of contraception for clients is one that will be in harmony with their wishes, fears, preferences, and lifestyles.

Many contraceptives are available today, but none of them is 100 percent safe or 100 percent effective. The most widely used are as follows:

- *Combined Oral Contraceptives.* Over 60 million women throughout the world are now using oral contraceptives. In most countries, the "pill" has been the most popular form of reversible contraception for the past two decades. In developed countries, pill use has reached about 24 million or 14 percent of married women in reproductive age. In developing countries, over 38 million or 6 percent of total married women use the pill.
- *Centchroman.* Centchroman, a non-steroidal contraceptive pill, is a product of CDRI Lucknow. It is taken once a week. It is safe and economical. It is sold under the names of Saheli and Centron. When used

correctly centchroman has a pregnancy rate of 2 per 100 women.

- *Progestin-only Injectable Contraceptive.* Injectable contraceptives, which contain only progestin, were developed in the 1950s. They were first used for treatment of endometriosis and endometrial cancer as well as painful menstrual periods, excessive hair growth, and bleeding disorders. By the 1960s, studies had shown that they were highly effective contraceptives. Currently, more than 10 million women in 100 countries, including India and the United States, are using progestin-only injectables. There are two types of progestin-only injectables: depot-medroxyprogesterone acetate (DMPA) which is a 150 mg injection given every 3 months, and norethindrone enanthate (NET-EN) which is a 150 mg injection every 2 months. The Government of India approved the use of DMPA and NET-EN in the private sector in May 1993. MaxPharma markets DMPA under the brand name Depo-Provera 150, while German Remedies market NET-EN as Noristerat. Neither injectable is available through the National Family Planning Programme.
- *IUCD.* At present, it is estimated that over 100 million women are using IUCDs, of which 67 percent are in China, 4.5 percent in Indonesia, 3.5 percent in Vietnam, 3 percent in India, and 22 percent in all other countries. Although in the past IUCDs have been made in various shapes and of different materials, currently only three types of IUCDs are available worldwide: (1) Inert, made of plastic (Lippes Loop) or stainless steel (the Chinese ring); (2) Copper-bearing, which include the TCu-200b, TCu-380A, Multiload (MLCu-250 and 375) and the Nova T; and (3) Medicated with a steroid hormone such as the progesterone containing progestasert and the newly developed levonorgestrel-containing LevoNova. Currently in India the following IUCDs are available: (1) Copper T 200B; (2) Copper T 220C; (3) MLCu-250 and 375; (4) Nova T; (5) Nugard 380; and (6) Zicoid 350.
- *Condoms.* Barrier contraception has been used since ancient times. The most popular barrier contraceptive in India today is the condom. There are several condom brands in India. Condoms are important since latex condoms are the only method by which there is protection against sexually transmitted diseases including HIV/AIDS.
- *Natural Family Planning.* Natural family planning is the application of fertility awareness in conjunction with certain rules by which the couples can avoid pregnancy. Natural family planning is defined by the World Health Organization as methods for planning and preventing pregnancies by observation of the naturally occurring signs and symptoms of the fertile and infertile phases of the menstrual cycle, with the avoidance of intercourse during the fertile phase if pregnancy is to be avoided. Methods of natural family planning include the cervical mucus method, the basal body temperature method, the sympto-thermal method, and the rhythm method.
- *Lactational Amenorrhoea Method (LAM).* Before the introduction of modern contraception, breastfeeding was the main factor determining the interval between pregnancies. LAM, which is based on the natural infertility experienced by breastfeeding women, especially during

the early postpartum months, was developed and is now being offered as a contraceptive choice to women.

- *Surgical Contraception.* Worldwide voluntary sterilization is the most popular and most effective method of long-term contraception. In women, the voluntary sterilization procedure involves blocking the oviducts (fallopian tubes) while in men the ducts containing sperm (vas deferens) are occluded. The female sterilization procedures are laparoscopic tubal sterilization and minilaparotomy. The male sterilization procedures are conventional vasectomy and no-scalpel vasectomy.
- *Emergency Contraception.* Emergency contraception is defined as methods women can use after intercourse to prevent pregnancy. Currently there are two types of emergency contraceptives—hormonal and mechanical. The most commonly used option is hormonal: a regimen of combined oral contraceptive pills. The mechanical method is inserting a copper-releasing IUCD within five days after unprotected intercourse, which prevents the pregnancy from being established.

Role of Advocacy in Reproductive Health Services

Marta Levitt Dayal

While the first National Family Planning Programme was initiated in India in 1952, it was during the 9th Five-year Plan in 1996 that the RCH programme integrated all related programmes to provide need-based, client-centered, demand-driven, high-quality RCH services. The programme has recognized that progress towards achievements in reproductive health and population can be realized when policymakers, programme planners and implementers, service providers, local opinion leaders, NGOs, the community, families and women themselves all become aware of the issues and their solutions and are empowered to take action. This recognition has led to initiatives that use advocacy and networking as critical components of any reproductive health programme.

What is Advocacy? Results achieved through advocacy and networking in the last decade have been very impressive. In 1994, a network of NGOs secured agreement from 179 countries on the issue of reproductive health at the ICPD. While many organizations and projects refer to advocacy, the definition of advocacy varies among the groups and networks that use it as a tool to create change. The Population Council states that advocacy, in the current context, "refers to a process that brings about change and ensures accountability within the system." The POLICY Project, through its training on advocacy, teaches that it is first and foremost a process, occurring over unspecified amounts of time, sometimes brief and often lengthy. Advocacy is also strategic and targets well-designed activities and specific messages to achieve a set of targeted actions directed at key stakeholders and decision makers in support of a specific policy or programme issue.

Advocacy has been traditionally directed at influencing policy, laws, regulations, programmes, or funding—decisions made at the upper most levels public or private sector institutions. However, in more recent years, as programme planning and decision making are decentralized and as development experts

recognized the tremendous influence of family and community decision makers, advocacy activities have been re-directed at decision makers at the district, grassroots, and familial levels. In India, where the 73rd and 74th Amendments of the Constitution ensures a 33 percent reservation for women in panchayats and locally elected bodies, female pradhans have become both the target for advocacy activities to gain their support for RCH services and a potentially powerful cadre of advocates for reproductive health rights and services. The tools and techniques used in advocacy efforts include a wide range of activities from coalition building, networking, lobbying, harnessing the media, conducting long-term strategic planning exercises, campaigning, rallying, to sensitization of policymakers and opinion leaders. For advocacy to be fully effective, a combination of scientific research, technical competency, organizational development, management expertise, and artistic talents are required.

Advocacy and Reproductive Health in India. In addition to upgrading facilities and provider skills and develop an effective management information system within the public sector, the Government's RCH programme aims to effectively bring all RCH services within easy reach of the community and to broaden ownership of the community in the programme. The programme aims at improving the outreach of services primarily for the vulnerable and underserved population by involving NGOs, advocacy groups, and voluntary organizations in the planning process, in increasing outreach and making this remarkable programme a people's programme. One intervention being promoted in the programme is enhanced community participation through NGOs, panchayats, and women's groups.

Advocacy and Reproductive Health in Uttar Pradesh and the IFPS Project. The IFPS Project, a 10-year partnership between the Governments of India and the United States, is reducing fertility by generating demand, increasing access, and improving quality of reproductive health services in 29 districts of Uttar Pradesh. Going beyond the walls of health facilities to reach out to eligible couples, the project uses a number of innovative approaches to create enabling environments for reproductive health. In 1998–1999, SIFPSA supported a programme that oriented and mobilized more than 4,000 female and male pradhans for reproductive health in six districts of Uttar Pradesh. Pradhans had an opportunity to learn the basics of family planning/MCH through interactions with doctors, to map out the RCH resources of their own panchayats and discuss their role in improving the reproductive status of their communities. This brief orientation was then followed several months later by a re-orientation held during an RCH camp organized by SIFPSA. Pradhans were provided a tour of the camp, learned about the constellation of RCH services provided, and observed the improved quality of service provision. One pradhan after completing the tour remarked, "I had no idea that such quality services were provided so close to my village." This re-orientation resulted in pradhans actually bringing clients into the camps.

In conclusion, the realization of reproductive health and reproductive rights requires support from a wide range of actors, stakeholders, activists, and decision makers

from the grassroots to policy levels through networking and advocacy that complements the service delivery approach and is focused on action. Any population policy will benefit by incorporating advocacy—its tools, methods, and goals—as it strives to create an enabling environment for positive change and securing of rights.

SESSION X

IDENTIFICATION OF POLICY ISSUES: GROUP DISCUSSION

Chairperson: *P.M. Kulkarni*

Identification of Policy Issues: Public Sector
Group I

Identification of Policy Issues: Private Sector
Group II

Identification of Policy Issues: Intersectoral Coordination
Group III

Session X

Identification of Policy Issues: Group Discussion

Chairperson Remarks

P. M. Kulkarni

So far, the workshop discussed various issues related to fertility behaviour, contraceptive use, MCH services, programme management, intersectoral coordination, linkages with the private sector, gender issues, and advocacy. There are several achievements and challenges identified. In the previous session, the participants in three have discussed policy issues related to the public sector, private sector, and intersectoral coordination. These group discussions provide us valuable insights into policy issues and strategies to achieve replacement level fertility in Uttar Pradesh by 2021.

Group I: Policy Issues: Public Sector

Jyoti Vajpayee

Group I has discussed the policy issues and strategies to reach replace level fertility by 2021 with a particular focus on the public sector. So all the strategies suggested and issues identified relate to the public sector. The recommendations follow.

The public health system should be reorganized to be made more effective and efficient and to suit the needs of RCH programme implementation. Public health infrastructure should be strengthened, manpower planning should be done, and vacancies should be filled. Decentralization of power is an important issue. Effective steps should be initiated to decentralize decision making both in terms of administrative and financial powers. At present, medical officers in-charge of PHCs and CHCs have administrative and financial powers. It is only the chief medical officers at district level who have all the authority. If the administrative systems are decentralized, programme implementation will improve.

There are inordinate delays in the flow of funds from one level to the other within the administration and also the release of funds is not timely. Given this, there is an urgent need to have alternative mechanisms for the flow of funds without delays. Severe constraints experienced by the state also call for identification of mechanisms to generate additional resources. Additional resources are needed continually to strengthen infrastructure and to maintain the infrastructure already in place. There are two ways of overcoming this problem. First, there should be a rational distribution of funds, and there should not be any wastage. Second, there should be user charges for curative services at secondary and tertiary hospitals, which would generate additional resources.

In addition to these measures, health insurance policies should be encouraged in rural areas. Another area for income generation is training. Now only public health sector personnel receive training in health institutions, and these facilities should be thrown open to the private sector for a fee. With these changes, the public sector can generate additional resources. Also, these funds are in addition to the usual budgetary allocations and, therefore, are flexible resources. The state Government should enhance the family welfare budget.

Policies for development of human resources are needed. First, all the vacant positions should be filled. If recruitment is not possible, contractual appointments should be allowed. This should be followed by skill upgrades of all personnel. Supervisory systems should aim at providing an enabling atmosphere and necessary support. This will considerably increase job efficiency. Transfers, promotion, and career development policies should be reviewed and rationalized. Right now morale of health department personnel is very low. There is no recognition for good work and no accountability. There is also a lack of discipline because people stopped taking pride in their work. If there is recognition for good work, then people take their work more seriously. The recognition may not be in terms of financial incentives but in terms of giving merit certificates. The male health workers have been transferred to panchayat system.

Planning should be decentralized. Efficiency should be improved and wastage should be eliminated, particularly wastage of contraceptives. Male participation should be promoted to encourage use of male methods of contraception and to promote responsible parenthood. IEC from the state to village level should be strengthened by formulating a comprehensive communication strategy and strengthening the existing IEC system.

Public sector right now needs image building exercise. Facilities are there and qualified persons are available to provide services but people are not utilizing the public sector health facilities. Management information systems are very weak and they need to be streamlined. To develop enabling environment at service delivery points, skills of providers should be improved, services should be client-centered and incentives to family planning acceptors should be stopped. Incentives create mistrust between providers and acceptors. Another area that needs attention is expanding contraceptive choices. Injectables should be made available in the public sector so that the clients who can not afford buy these services from private sector have access to services. A strategy should be developed to include emergency contraception in the regular programme.

Group II: Identification of Policy Issues: Private Sector

Roop Kamal

Private sector contributions to access, quality, and demand have been discussed in this group. How to involve the private sector is a major issue. There is a need to create a mechanism such as an autonomous body for effective management and also to facilitate the flow of funds. Coordination of activities of the private sector with that of panchayati raj

institutions (PRI) should be encouraged. This can be done by involving private sector representatives in PRI health committees. Similarly, NGO coordination committees should be established at district levels. To monitor all activities of NGOs, an effective MIS should be in place.

Potential private sector partners include NGOs. Several NGOs are working in other development sectors but not in the health sector. The potential of these NGOs should be exploited. Other private sector partners include private doctors, particularly lady doctors, ISM practitioners, commercial outlets, private hospitals and clinics, the corporate sector, dairy and other cooperatives. Some of the key areas in which the private sector can contribute include service delivery, social marketing, demand-creation, expanding contraceptive choice, improving the quality of services that are client-focused, and advocacy

Service Delivery. The community-based distribution approach, as implemented in several projects, is an effective service delivery strategy. Other service delivery strategies could be mobile outreach and static clinical services. PHCs and CHCs and urban health posts should be contracted to PVOs. Involvement of traditional birth attendants (TBAs) and ISM practitioners should be encouraged. Youth-friendly RCH services should be handled by the private sector. Private nursing homes should be involved in providing clinic-based services. There is a need to change the image of the family welfare programme from a state-owned programme to a people's programme. To facilitate this new image, there will be no incentives or disincentives for the people. Incentives and disincentives reinforce the old image.

Social Marketing. The commercial trade channels are playing a major role in making condoms and oral pills accessible to the people. There has been a considerable shift in recent times from the public sector as a source of supply to the private sector. The potential of this sector should be fully exploited. Another potential that exists is the vast network of public distribution systems in the state. This could be used to distribute contraceptives. To sustain private sector NGO projects, social marketing should be introduced. Social marketing in the NGO sector will succeed only when capacity is built by training all personnel working for the project.

Demand Generation. Implementation of IEC activities through the private sector will be more effective. Innovative strategies aimed at behaviour change can be tried. Private sector projects should have interpersonal communication as an important component. Training should be imparted to private sector service providers on counseling skills.

The private sector, as per GOI regulations, can provide injectables. A demonstration project should be funded in the private sector to encourage the use of injectables. All private sector projects should introduce emergency contraception as an important component of their projects. Private sector projects should concentrate more on RCH services and not on family planning alone. The private sector should be involved in managing the contraceptive distributions system to avoid stock-out situations. Capacity building of the

private sector is another important component that needs attention. Private and public sector linkages should be strengthened to improve the referral system.

Advocacy at the implementation level is key to the success of the programme. Block development officers and the media should be involved to make them aware of the type of services provided. The private sector can also play a role in monitoring the programme performance of the public sector and also in evaluating different components of the public sector programme.

Group III: Identification of Policy Issues: Intersectoral Coordination

Ashok Das

The group has discussed intersectoral coordination taking into account the interdepartmental coordination and also the coordination between public and private sectors. To achieve replacement level fertility by 2021, the first step required is population advocacy and activism. For this, public and private sector partnership is required, and we should develop strategies to build this partnership and strengthen it. This is particularly relevant in the case of panchayati raj institutions and urban local bodies. Panchayati raj institutions and urban local bodies should understand the issues and challenges involved and should own the programme.

For the past 40–50 years, the programme has been considered as a medical or health department programme. Family planning is not a health problem. The medical department's involvement is necessary to provide clinic-based services. The main issue involved in the family planning programme is behaviour change at the individual and community level. Community involvement is essential.

In Uttar Pradesh, there are a large number of vacant positions at various levels. In such areas, services of allied departments should be used. It could be a hand pump mechanic, dai, or teacher living in the community. Another important issue is convergence. For intersectoral coordination, the Government departments should be divided into three main categories: the departments in the core circle, a middle circle, and an outer circle. All those departments that can directly contribute to population stabilization should in the core circle. These include education, water sanitation, women and child development, panchayats, social welfare, and information and publicity. The middle circle consists of departments like animal husbandry, forests, and a few other departments. The outer circle consists of remaining departments.

Having identified the intersectoral approach, we need to discuss the operational mechanism. The group strongly felt that a bottom-up approach should replace the top-down approach. In the bottom-up approach, the panchayati raj institutions have to play an important role. There are health and family welfare committees at the panchayat level facilitated by panchayat development officers. Community representatives should implement the programme, act as catalysts, organize services, and monitor programme performance. Similar efforts should be made in urban local bodies. Convergence of service delivery systems at the grassroots level is easy

with elected local bodies taking a lead role in programme implementation. The convergence should lead to combined training, joint visits to the field, and joint campaigns. Wherever there are a health and social welfare committees, be it at the local, district, or state levels, there should representatives from an expert group, NGOs, and other private sector representatives in the committees.

VALEDICTORY SESSION

Opening Remarks

Shri Bachchi Lal, Director General, Family Welfare, Government of Uttar Pradesh

Address

Sushri Kristin Loken, Deputy Director, Population, Health and Nutrition Division, USAID, New Delhi

Address

Sushri Aradhana Johri, Executive Director, Society for Innovations in Family Planning Services Project Agency (SIFPSA), Lucknow

Address by the Chief Guest

Shri Ramapati Shastri, Minister for Health, Government of Uttar Pradesh

Vote of Thanks

Shri Gadde Narayana, Country Director, POLICY Project, The Futures Group International

Session XI

Valedictory Session

Shri Bachchi Lal, Director General, Family Welfare, Government of Uttar Pradesh

It is an occasion of great happiness for us that the Honourable Minister of Medicine and Health is present among us. The three-day workshop is coming to an end now. The participants of this workshop, jointly organized by The Futures Group International and the Government of Uttar Pradesh, include representatives of several national and international organizations, experts from the private and public sectors, and the media. Experts presented more than 25 papers in this workshop. Subjects of these papers included trends in population growth, implications of population growth, and RCH programme issues. Major issues discussed included AIDS, STIs, RTIs, decentralization of programme implementation, skill development for medical and paramedical personnel, the role of panchayati raj institutions, community involvement, intersectoral coordination, and the status of women.

After presentation of all papers, three working groups were formed to identify policy issues in regard to the public sector, private sector, and intersectoral coordination. The major recommendations of these working groups are that the reach of services should be expanded, the quality of services should be improved, demand for services should be generated; the private sector should be involved in service delivery, community participation should be ensured, and advocacy should be taken up at all levels. The programme should be developed into a people's movement. I sincerely hope that the recommendations of this workshop will go a long way in helping to formulate a population policy.

Sushri Kristin Loken, Deputy Director, PHN Division, USAID, New Delhi

Shri Ramapati Shastri, Ms Aradhana Johri, Dr Narayana, and Dr Bachchilal, I congratulate the Government of Uttar Pradesh for holding this workshop. As a Government employee myself, I know it can be difficult-sometimes even painful- to take an objective look at your own functioning. I felt a sincere and honest involvement by public officials to identify problems and solutions to better meet the reproductive health needs of the Uttar Pradesh population. I am also very impressed by the high quality of expertise gathered in this room. I appreciate the role of demographers for being very clear about the strengths and limitations of statistical data and the appropriate use in the formulation of population policy and all the participants for their excellent and insightful contributions and willingness to share their experience. I am

impressed too by everyone's willingness to take into consideration sensitive issues such as:

- expanding contraceptive choice, to include Injectables,
- role of incentives,
- user fees for public sector services.

As we go forward into this millennium, these issues must be dealt with if reproductive health goals are to be met in Uttar Pradesh. I was very pleased to hear the several references to a people's population policy.

Thank you very much for the opportunity to participate in this exciting workshop and I look forward to future steps in this process.

Sushri Aradhana Johri, Executive Director, SIFPSA, Lucknow

The Honourable Minister, our esteemed guests and friends, we have discussed all the issues relating to population during the last three days. As Dr. Bachchi Lal said, and as you are aware, this group is diverse in nature. We have researchers, demographers, technical experts, representatives of national and international donors, officials from other states, representatives of non-Governmental organizations, officials from medical departments, and others. This diversity will ensure the contribution of various groups to the formulation of policy. Dr. Bachchi Lal has already told us about detailed discussions during this workshop. These discussions have revealed that although we have made some progress, there is still much to be done to reach the national average.

We have discussed in detail the work being done by voluntary agencies, the corporate sector, panchayats, fertility behaviour, trends in contraceptive use, RCH services, etc. There is a need to establish coordination among the department of education, ICDS, and other departments of rural development. The participants have also discussed the fresh measures taken up in Uttar Pradesh and other states and the ways to make these measures workable. Decentralization has been the focus of our discussions. During the last 1–2 years, Uttar Pradesh has taken initiatives in decentralization in the field of health. In the morning session, we discussed the issue of women's empowerment in which the level of interaction and participation was quite high. Most significant is that our discussions were diverse in nature and we did an honest stock taking. We discussed what has been done, what needs to be done, which initiatives have to be carried forward, and what ways must be adopted to further our efforts. It was not only an honest and positive stock-taking exercise but also an open interaction. We found that we have limited time. In the morning, the working groups submitted their recommendations which underlined the role of the Government sector, corporate sector, and other related sectors, the need for developing linkages with various sectors, and the required inputs for our policy.

It has also been emphasized that we must make an effort to achieve a total fertility rate of 2.1 by 2021. We discussed the strategy to achieve the goal. So we have many good suggestions for formulating the policy. In view of this, we are quite hopeful that a well-coordinated policy will be worked out that will not be just a Government policy but a policy with the contribution of all stakeholders.

In the end, I would like to thank the Honourable Minister for giving his consent to participate in this session, in spite of his busy schedule on this day of Shivaratri. The high-level of political commitment will make this policy successful.

Shri Ramapati Shastri, Minister for Health, Government of Uttar Pradesh

The Executive Director of SIFPSA, Ms. Aradhana Johri, Ms. Loken, and all experts and participants. You have worked hard for the last three days. On the inaugural day our honourable Chief Minister was present. Several senior officials from the state participated in the discussions. The population of Uttar Pradesh was 6–7 crores before independence. At that time, population growth was not as high. In recent times, the population growth rate has increased considerably. We need to control population growth. We will derive immense benefit from the discussions in the workshop and the suggestions given. Now in our state, there is a provision made for involvement of panchayats, but more emphasis should be given to this aspect. In any democratic society, political participation is a must for any programme to succeed. A country cannot develop its democratic tradition without political participation. I assure you that the Uttar Pradesh Government will ensure political participation and extend cooperation to the population control efforts.

The concepts of small family and limited population size is quite old. Our sages and saints adhered to the norm of a small family. Rama has two children. I visited Chennai recently, and they were promoting the concept of "one family, one child." Pandit Nehru had one child and our Prime Minister has no children. We will have to adhere to this norm as a political commitment.

Large families are due to illiteracy. People think a big family is an asset. This very notion of viewing children as assets makes them beggars. In small states like Punjab and Kerala, resources available at the household level are due more to small family size. I would like to strongly put forward a point here. Why should the entire burden of reducing family size be thrust on women only? It is women who have to use the Copper T, go for operation, and use oral contraceptives. Once the men in Uttar Pradesh decide to adopt a small family norm, we can achieve within 10 years what we could not in the past 50 years. For bringing improvement in the society, individuals have to mend themselves. Deendahalji once said, "If the individual is mended, the family will improve, and this in turn will improve the nation." We will start our work from our families and our localities based on the suggestions given by you.

The Government of India has already formulated a population policy. Uttar Pradesh should have one. We will discuss the policy in the Cabinet Sub-committee and make it more effective. This is a difficult task as the resources at our disposal are limited. If the present situation continues, we will not be able to walk on roads in the coming 10–15 years, we will have to use helicopters. But I am sure that by working together, we can carry forward this task. Once again, I would like to emphasize that the responsibility should not be thrust upon women alone, and men should effectively participate in the programme.

Vote of Thanks

Gadde Narayana, Country Director, POLICY Project, The Futures Group International

This was a three-day workshop with more than 100 participants and 25 papers. There has been considerable debate on various issues, sometimes up to late in the evening. All the issues raised will help to shape the document.

I would like to thank Shri Ramapati Shastri who has, in spite of his several other commitments, kindly agreed to attend the valedictory session. He has assured us that there is political will in the state to stabilize the population. He has rightly pointed out that male participation should be the central theme of the Uttar Pradesh population policy. In fact, the Chief Minister inaugurated this workshop, the Chief Secretary not only attended the inaugural session but also chaired a session on "Advocacy and Family Planning", and your presence here is a manifestation of the political will this state has to formulate a population policy. This workshop is a first step in this direction. I would like to thank the honourable minister for his advice on various aspects of policy.

I would like to thank Ms. Kristin Loken, who has keen interest in a participatory approach to policy formulation. In spite of her busy schedule, particularly these days with the forthcoming Clinton visit, she attended the workshop and contributed to the discussions. Mr. V. K. Dewan has taken a lead role right from the beginning, and Dr. Bachchi Lal was present for all sessions. I would like to thank both of them for their contributions. Another partner in this effort is SIFPSA. Several from SIFPSA contributed to the workshop. First and foremost, I would to thank Aradhana Johri, who from the planning stage to this minute was deeply involved in this effort, provided guidance, advised on several issues, and participated in the workshop proceedings. I would to like to thank Mr. Deepak and Dr. Rakesh Kumar who extended all possible support to make this workshop successful. I would also like to thank authors of all papers, discussants, and participants. I would like to thank the media representatives. The issues raised here and the suggestion given will definitely find their reflection in the policy document.

Annexure I

Workshop Agenda

Workshop on Population Policy for Uttar Pradesh: Identification of Issues
March 2-4, 2000
Hotel Taj Mahal, Lucknow

March 2, 2000

10.00-11.00

Inaugural Session

Welcome and Introduction to Family Planning Programme in Uttar Pradesh
Shri V.K. Dewan, Principal Secretary, Medical, Health and Family Welfare, Government of Uttar Pradesh

Address
Sushri Kristin Loken, Deputy Director, Population, Health and Nutrition Division, USAID, New Delhi

Address
Sushri Aradhana Johri, Executive Director, Society for Innovations in Family Planning Services Project Agency (SIFPSA), Lucknow

Address
Shri Gautam Basu, Joint Secretary, Ministry of Health and Family Welfare, Government of India, New Delhi

Address by the Guest of Honour
Shri Yogendra Narain, Chief Secretary, Government of Uttar Pradesh

Presidential Address
Shri Sardar Singh, Minister for Family Welfare, Government of Uttar Pradesh

Chief Guest Speech
Shri Ram Prakash, Chief Minister of Uttar Pradesh

Vote of Thanks
Shri Gadde Narayana, Country Director, The POLICY Project, The Futures Group International

11.30-13.00

Session 1: Population of Uttar Pradesh

Chairperson: Mr. V.K. Dewan

Uttar Pradesh: Population Trends
Ms. Sheena Chhabra

Recent Trends and Regional Variations in Fertility in Uttar Pradesh: Causes and Correlates
Dr. P.N. Mari Bhat

Fertility Transition in Uttar Pradesh
Dr. F. Ram, Dr. Arvind Pandey, Dr. T.K. Roy, Mr. Zaheer Khan

Discussants: Dr. P.M. Kulkarni and Dr. T.K. Roy

14.00-15.15

Session 2: Contraceptive Use and Behaviour

Chairperson: Mr. Gautam Basu

Contraceptive Use in Uttar Pradesh: Recent Evidence and Policy/Programme Implications
Dr. T.K. Roy, Mr. Ravi Verma, Dr. Arvind Pandey

Contraceptive Use and Sources of Supplies in Uttar Pradesh
Dr. K.M. Sathyanarayana, Dr. G. Narayana

Discussants: Dr. Tara Kanitkar and Dr. Sumati Kulkarni

15.45-17.15

Session 3: Reproductive and Child Health Services in Uttar Pradesh

Chairperson: Dr. Saroj Pachauri

HIV/AIDS Programme in India and Uttar Pradesh
Dr. Subhash Salunke

Reproductive Tract Infections: Programme Implications
Dr. Subhash K. Hira

Special Campaigns for Maternal and Child Health Services: Innovative Approaches in Uttar Pradesh
Ms. Aradhana Johri

Maternal and Child Health Care in Uttar Pradesh
Dr. Kamala Gupta

Discussants: Ms. Cristina Arismendy and Dr. M.C. Gupta

March 3, 2000
09.30-11.00

Session 4: Management of Health and Family Welfare Programme in Uttar Pradesh

Chairperson: Mr. A.P. Verma

CNA Approach in Uttar Pradesh: Programme Performance
Mr. J.S. Deepak

Contraceptive Logistics Management in Uttar Pradesh
Dr. G. Narayana

IEC for Demand Generation and Information Sharing
Mr. V.S. Chandrashekhar

Training Programmes for Skill Development: Policy Implications
Dr. Patricia M. Gass

Discussants: Mr. Arun Kumar Sinha and Dr. V.K. Srivastava

11.30-13.00

Session 5: Decentralization of Programme Implementation

Chairperson: Dr. Nina Puri

Need for Decentralization: An Analysis of Organization Structure
Mr. J.S. Deepak

Decentralized District Action Plans: Issues and Challenges
Ms. Aradhana Johri

Role of Panchayats in Decentralized Health Administration
Mr. A.P. Verma

Unmet Need for Family Planning and VIKALP Experiment: Implications for Uttar Pradesh
Dr. Devendra Kothari

Discussant: Dr. Rameshwar Sharma

14.00-15.15

Session 6: Linkages with Other Departments

Chairperson: Mr. S.P. Gaur

Multi-Sectoral Approach to Health and Family Welfare in Uttar Pradesh
Mr. K. Chandramouli

ICDS Programme in Uttar Pradesh
Mr. Krishna Gopal

Rural Development Programmes in Uttar Pradesh
Mr. Nasim Zaidi

Discussants: Mr. Ashok Das, Mr. Saurabh Chandra and Dr. Bachchilal

15.45-16.45

Session 7: Advocacy and Media

Chairperson: Dr. Yogendra Narain

Facilitators: Mr. V.K. Dewan
Mr. Gyanendra Sharma
Mr. Udai Sinha
Dr. Gadde Narayana

16.45-17.30

Session 8: Role of Non-Government Organizations in Uttar Pradesh

Chairperson: Ms. Kristin Loken

Role of NGOs in RCH Programmes
Dr. Marta Levitt Dayal

Involving Milk Cooperatives in Family Planning in Uttar Pradesh
Mr. R.C. Awasthi

Role of Organized Sector in Family Planning in Uttar Pradesh
Mr. C.B. Tiwari

Discussants: Dr. Nina Puri and Dr. Rakesh Kumar

March 4, 2000

09.30-10.45

Session 9: Gender Issues, Advocacy and Informed Choice

Chairperson: Ms. Aradhana Johri

Status of Women in Uttar Pradesh: Empowerment of Women
Dr. Sumati Kulkarni

Informed Choice and Contraceptive Technology
Dr. Jyoti Vajpayee

Role of Advocacy in Reproductive and Child Health Services
Dr. Marta Levitt Dayal

Discussants: Dr. L.V. Prasad, Dr. Siddh Gopal and Mr. Lov Verma

11.15-13.15

Session 10: Identification of Policy Issues: Group Discussion

Chairperson: Dr. P.M. Kulkarni

Group I: Identification of Issues: Public Sector

Group II: Identification of Issues: Private Sector

Group III: Identification of Issues: Inter-Sectoral Approaches

15.30-16.30

Valedictory Session

Opening Remarks
Dr. Bachchi Lal
Director General, Family Welfare, Government of Uttar Pradesh

Address
Sushri Kristin Loken, Deputy Director, Population, Health and Nutrition Division, USAID, New Delhi

Address
Sushri Aradhana Johri, Executive Director, Society for Innovations in Family Planning Services Project Agency (SIFPSA), Lucknow

Address by the Chief Guest
Shri Ramapati Shastri, Minister for Health, Government of Uttar Pradesh

Vote of Thanks
Shri Gadde Narayana, Country Director, The POLICY Project, The Futures Group International

Annexure II

List of Participants

1. Dr. A.K. Dwivedi
   C.M.O.
   Varanasi

2. Mr. Amit Mehrotra
   Asst. Project Coordinator (Pvt. Sector)
   SIFPSA
   Om Kailash Tower,
   19-A, Vidhan Sabha Marg,
   Lucknow

3. Dr. Anand Sarup
   Additional Director
   Medical, Health & Family Welfare
   Meerut/Sultanpur Division
   Meerut
   UP

4. Ms. Ananta Singh
   Project Coordinator (Pvt. Sector)
   SIFPSA
   Om Kailash Tower,
   19-A, Vidhan Sabha Marg,
   Lucknow

5. Dr. Anurag
   Joint Director
   Directorate of Family Welfare
   Govt. of UP
   Lucknow

6. Ms. Aradhana Johri
   Executive Director
   SIFPSA
   Om Kailash Tower
   Vidhan Sabha Marg
   Lucknow

7. Dr. Anjani Kumar
   Joint Director
   RCH
   Directorate of Family Welfare
   Jagat Narain Road
   Lucknow

8. Dr. Aruna Narain
   Assistant Director
   Directorate of Family Welfare
   Govt. of UP
   Lucknow

9. Mr. Arun Kumar Sinha
   Staff Officer to Chief Secretary
   Secretariat Annexe
   Lucknow

10. Dr. Asha Pandey
    Associate Director
    PPRC
    19, Laxmanpuri
    Faizabad Road
    Lucknow

11. Dr. Ashok Bapna
Professor, PRC
SIHFW, HCM RIPA Campus
Jaipur

12. Mr. Ashok Das
Secretary, Family Welfare
Govt. of Madhya Pradesh
138, Vallabh Bhawan, Mantralaya
Bhopal

13. Mr. Ashok Kumar Singh
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Abbreviations

ACR	Annual Confidential Report
AD	Additional Director
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
BMI	Body Mass Index
CBD	Community-Based Distribution
CBR	Crude Birth Rate
CHC	Community Health Center
CHW	Community Health Worker
CMO	Chief Medical Officer
CMS	Chief Medical Superintendent
CNA	Community Needs Assessment
CPR	Contraceptive Prevalence Rate
CSSM	Child Survival and Safe Motherhood
DAP	District Action Plan
DD	Deputy Director
DFWB	District Family Welfare Bureau
DG	Director General
DHEIO	District Health Education and Information Officers
DMPA	Depot-Medroxyprogesterone Acetate
ECR	Eligible Couple Register
FW	Family Welfare
GOI	Government of India
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IDU	Intravenous Drug User
IEC	Information, Education, and Communication
IFA	Iron and Folic Acid
IFPS	Innovations in Family Planning Services
IRDP	Integrated Rural Development Programme
ISM	Indigenous System of Medicine
IUCD	Intrauterine Contraceptive Device
MCH	Maternal and Child Health
MIS	Management Information System
MMRC	Media/Materials Resource Centre
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer In-Charge
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NET-EN	Norethindrone Enanthate
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NIHFW	National Institute of Health and Family Welfare

OBC	Other Backward Classes
OR	Operations Research
ORS	Oral Rehydration Salts
PHC	Primary Health Center
PMU	Project Management Unit
POL	Petrol, Oil, and Lubricants
PRC	Population Resource Centre
PRI	Panchayati Raj Institution
PVO	Private Voluntary Organization
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
SHG	Self-Help Group
SIFPSA	State Innovations for Family Planning Services Project Agency
SRS	Sample Registration System
STI	Sexually Transmitted Infections
TFA	Target-Free Approach
TFR	Total Fertility Rate
TT	Tetanus Toxoid